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# BIOETHICS OUTLOOK

*John Plunkett Centre for Ethics in Health Care*

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## In this issue

- The first piece in this edition of *Bioethics Outlook* is a transcript of the "after-dinner" talk given by Dr Brian Dwyer at the Plunkett Centre's second annual Intensive Bioethics Course. Dr Dwyer is a retired anaesthetist who set up the Intensive Care Unit, the Pain Clinic and the Palliative Care Unit at St Vincent's Hospital in Sydney. His talk has been transcribed almost verbatim: it thus has the flavour of a speech to be listened to rather than a paper to be read!

- Keith Joseph then discusses the role of the "clinical ethicist" in Canadian hospitals.

- In the next piece, "Why voluntary euthanasia should not be legalised", Gerald Gleeson draws on the paper presented by John Quilter at a Plunkett Seminar in November last year.

- Finally, Bernadette Tobin comments on two features of the "model euthanasia legislation" proposed by the Aids Council of New South Wales. She points out that ACON's proposal confuses euthanasia with suicide, and that it widens the scope of those who could legitimately request euthanasia to include those with an unsatisfactory 'quality of life'.

## “In my prayers I asked outright for wisdom.”

*Brian Dwyer*

As an aged medical retiree I feel somewhat like a fish out of water addressing such an audience which is devoted to improving its collective understanding of bioethics! I have no profound knowledge of the subject. Fortunately for me, after dinner speeches should be more for entertainment than education! But even in this situation I am uncomfortable. I feel rather the way Mr Graham Gooch, a retired English Cricket Captain, must have felt when he was resurrected, dusted down and sent to Australia to defend his country's honour in the recent "Ashes" series. Even as entertainment value most thought he was "over the hill" – and, mind you, he was only forty-one!

Tonight, with your indulgence, I thought it best if I simply reviewed some experiences of my medical career which, for me, had a major bearing on ethics at the time and not surprisingly continue to be important issues of debate and discussion.

As my story is a personal view through a very small window of medical practice over the past fifty years, I should define for you now the limits of my experience. Essentially I was a specialist

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anaesthetist, seemingly directed by fate to establish over a thirty year period, successively, an Intensive Care Unit, Pain Clinic and finally, a Palliative Care Service at St Vincent's. Perhaps you will now appreciate the relevance of the theme for this talk which, at all times, reflected my greatest need. With Ben Sira I would say that:

*"In my prayers I asked outright for wisdom."*<sup>2</sup>

As an undergraduate in medicine at Sydney University from 1943 to 1948, like all other undergraduates I had virtually no exposure to medical ethics except for two or three afternoon lectures in 1945. The Hippocratic Oath, the rules of medical practice and the permissible extent of advertising were explained. For some understanding of how to manage the life and death issues which were to surface with the first patient contacts as a new intern in a hospital, one had to fall back on one's moral upbringing through parents, school and the Church, all of which was underpinned by some immanent sense of good and evil, right and wrong. In my own case the path to follow seemed to be:

- Fear God and his punishment.
- Fear women for their potential to induce questionable thoughts or actions.
- Respect all human life and personal property.
- Love one's parents and neighbours, and
- Avoid the law and be polite to policemen!

Valuable as this background may have been, it failed to fill the ethical vacuum you felt when the awesome problems encountered in day-to-day hospital practice had to be resolved.

Fortunately, practical guidance soon came – mainly from the senior nursing sisters and older colleagues. In a haphazard way it was designed to prevent you causing patients some irreparable harm. You soon learned that miraculous cures were out of your reach. *"Primum non nocere"* was the first commandment of medical ethics.

While senior nurses exerted a necessary authority and demanded obedience, it is

pleasing to recall that the junior nurses who were more of one's own age had ideas which were more compatible with one's own and, indeed, more conducive to happier interpersonal relations.

As an intern one saw for the first time death and dying, cancer in all its manifestations, drug and alcohol abuse, senility, strokes (and their aftermath, unconsciousness), the effects of massive trauma, malformed children, Down's syndrome – the list goes on and on!

While all this was sad, at the same time it seemed to be inevitable. All you could do was to relieve some pain and discomfort and offer support to patient and family. Pneumonia was welcomed as "the old man's friend" when it occurred in an elderly patient perhaps dying from cancer or unconscious from a stroke. Anaesthesia was risky. Radical surgery was rarely performed and intravenous or tube feeding was never used for the dying. Patients received essential nursing and symptomatic relief while the priest or minister was always involved whenever death seemed imminent.

In this way, the process of dying was not drawn out by any treatment given in some forlorn hope of prolonging life. Nor were patients knowingly killed by direct active intervention. The disease process itself killed the patient, while doctor and nurse offered relief and comfort.

My life then took me in 1951 to Oxford where I became involved in a technological and pharmacological revolution which was to change the face of patient resuscitation and introduce major ethical issues which remain with us to this day. It happened in this way.

### **The Copenhagen Epidemic**

In 1952, a massive epidemic of bulbo-spinal poliomyelitis broke out in Copenhagen producing respiratory paralysis within a few weeks in over 700 people. They occupied all the urgent beds of the city's hospitals and, due to the inadequacy of the "iron lung", the only mechanical respirator then known, the early

mortality was approximately 100%. Patients were suffocating, literally drowning in their own saliva which, in turn, produced fatal pneumonia. At first, nothing seemed to help and people were despairing as their loved one died in front of their eyes. Then, a possible answer was discovered. This required the creation of an artificial airway through the trachea and then the manual ventilation of the lungs through a breathing tube placed in the trachea. A rubber anaesthetic breathing bag filled with air was squeezed ten to fifteen times per minute continuously day in and day out for weeks to simulate normal breathing.

All this was carried out by volunteers who were drawn from the ranks of medical students, families, nurses, friends, doctors – anyone who could be trained. The medical and many other services of the city were virtually brought to a standstill by this mass effort in resuscitation. In time the mortality rate progressively dropped to about 25% – truly, a remarkable achievement at least for the immediate acute phase of the illness. But a major problem continued which involved all the complications of the long term survival of patients who remained permanently paralysed and grossly disabled.

In time, technicians and anaesthetists designed and built new mechanical respirators which replaced the primitive manual methods, thus preparing the ground for long term respiratory support in patients with all types of respiratory failure.

## **The Dawning of a New Era in Resuscitation**

The next phase was a pharmaceutical revolution through the development of new drugs which could artificially maintain blood pressure, heart function, control convulsions and cure previously fatal infections. At the same time patients (both conscious and unconscious) could be sustained indefinitely by artificial feeding methods either via tube feeding or intravenous infusions of protein, fat or glucose or through direct intubation of the stomach or intestine.

Next, where thought to be indicated, a state of artificial hibernation or suspended animation

could be induced at will to lower body and brain metabolism by using drugs and the surface cooling of the body. Should the kidneys fail, their function could be taken over by dialysis. The body's skin covering, muscles and joints could all be protected by specialised physiotherapy and nursing.

The poor suffering body was then attached to an ever-increasingly complex and invasive monitoring system which recorded for posterity its physiological status at any moment.

What was usually not known during the days or weeks of this "State of the Art" resuscitation was how patients felt. Why? Because either they could not speak or they had been rendered semi-conscious by sedation. You can draw your own conclusions as to the effect all this might have had on confused and anxious relatives.

The enormous financial cost to the community and, often, to the patients was justified by the thought that some patients were now living who would otherwise have died. But, on the other hand, while some regained full health, others remained permanently incapacitated. One simply could not predict the final outcome at the beginning of the resuscitation programme with absolute certainty for any individual.

Now the questions that had to be asked came thick and fast as Copenhagen's resuscitation revolution had become global. A new medical discipline had appeared which was to require separate hospital wards, specially trained medical nursing staff and a mountain of sophisticated technical equipment to be purchased and installed.

Were we now exceeding the reasonable bounds of human endeavour? Were we unconsciously seeking to become God-like in our new-found power and authority over life? Or, were we simply acting as God's agents in applying our human response to a newly identified threat to life?

Today we ask: Should anyone die, or (perhaps more correctly) be allowed to die, without the full application of our modern medical and technical wizardry? May we ethically ever

withhold treatment? If this is permissible, when may we, and under what conditions? May we suspend active treatment once it had been commenced?

Should everyone be given the chance of survival under these extreme circumstances or should our efforts be confined to the young, potentially productive and previously fit members of our community? Or should this extraordinarily expensive treatment be given only to those who can afford it? Who, then, would be best qualified to make the necessary decisions – the attending doctor and his colleagues, the ethicist, the hospital management with its accountant and Board of Directors, the lawyers, especially those involved in litigation, or finally the Government? In each specific instance, those at the centre of all this profound confusion are a patient and the relatives (whose opinions may not be sought for various reasons or who may feel incompetent to interfere). Since all involved must have some influence on the steps to be taken, it is not surprising that such disparate groups may produce in the end a camel when they are seeking to create a horse!

When, in 1960, I established an Intensive Care Unit at St Vincent's and the onus of responsibility for these decisions was mine, I was fortunate to have had a flash of heavenly insight to which I have not publicly admitted before. I was given permission to name the new ward. I chose to name it after St Camillus de Lellis who was known as the patron saint of gamblers! What better guidance could one hope for when the chips were down and you had run out of ideas?

For me, Pius XII in February and November 1957 provided the first ethical guidelines so desperately needed by anaesthetists and intensivists. He said:

*"... if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts, and the doctor can lawfully comply. There is not involved here a case of direct disposal of the life of the patient,*

*nor of euthanasia in any way. Even when it causes the arrest of circulation, the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life."*<sup>3</sup>

Now I wish to refer briefly to another ethical dilemma of which we are all aware – that is, the treatment of patients with advanced cancer and other terminal illnesses which have similar physical, emotional, psychological and spiritual problems, including AIDS and multiple sclerosis.

To me, the issues involved here largely revolve around a profound ignorance of the potential of proper medical care, the lack of a basic understanding of the individual's needs and a total inability to interpret the deeper meaning of the patient's general cry for help. Sadly, those closest to these patients who are responsible for their total care – most commonly doctors – often seem unable to cope with death or the dying process in a positive and sensitive way. Their medical training has been inadequate and wrongly focussed in these matters. On the other hand, the protagonists of euthanasia, be they ethicists, philosophers, theologians or doctors, base their arguments on theoretical concepts of death, dying and suffering which have an anecdotal basis and, in general, lack personal experience of caring for numbers of such patients over a significant period.

Hans Kung, reflecting on euthanasia, supported the practice provided that the patients were old rather than young and that only a doctor could perform the act after seeking the agreement in consultation with other colleagues. On this basis one could imagine an ever-widening circle of doctors involved in this process, eliminating any future need for their education in palliative medicine and a rapid decrease in the community's confidence in the ethical standards of their doctors. There would be significant role changes in our community – disease would no longer kill people naturally, doctors would kill people unnaturally and God's role in the final decision would be redundant. Hippocrates, our icon of medical ethics, would now be dismissed as a silly old Greek.



Alternatively, one could follow the advice of a now-deceased orthopaedic surgeon who said to a particularly troublesome patient who had been hospitalised for some weeks with complicated leg fractures: "You know, Mr Smith, if you were a horse we would shoot you." Another easy way out for the harassed doctor, but hardly ethical!

Still, I would assert that to deliberately give a fatal dose of some drug to a distressed dying patient is also an easy way out. It is also unethical. It is murder. And it is unnecessary. There are alternative means available to relieve pain and suffering, which are admittedly not easy, since they require a presence, time, knowledge and sympathetic understanding of the whole patient's and relatives' needs. This is effective at the time and leaves none of the lingering doubts and guilt of "the quick fix" lethal injection.

The answer to the community's fears about death from cancer or related illnesses, and to those who seek to destroy another's life to ease the patient's burdens, lies in the knowledge and continuing refinement of palliative care medicine. This discipline must be taught at medical school and teaching hospital levels, to both nursing and medical graduates and to undergraduates through the medium of palliative care units attached to teaching hospitals.

In conclusion, I must say that my medical life has been clouded by my ignorance of philosophy, bioethics and moral theology. For the future it is my deepest hope that all involved in the professional care of the sick should be taught, according to their capacity, the essential truths of these subjects. Ethics departments should be active in every teaching hospital and be responsible for consultative advice for all hospital units. The John Plunkett Centre for Ethics in Health Care is an ideal model to follow.

Pat Walsh, lecturer in ethics at Kings College, London wrote recently in *The Tablet* "as follows:

*"The frequent criticism of doctors pressed to make ethical decisions for which their clinical training did not prepare them is, of course,*

*largely unfair. I am well aware of the resentment doctors and nurses feel when they are blamed both because they are thought to have over-reached themselves in deciding who shall live and who shall die and because they sometimes take refuge in appeals to purely clinical judgement. Nevertheless, the truth is that doctors are increasingly taking decisions which are more moral than clinical and that they are no better equipped to take such decisions than the man or woman on the Clapham omnibus."*

And finally for inspiration I offer Ben Sira's words in our own quest for wisdom:

*"When I was still a youth before I went travelling,  
in my prayers I asked outright for wisdom.  
Outside the sanctuary I would pray for her,  
and to the last I shall continue to seek her.  
From her blossoming to the ripening of her grape,  
my heart has taken its delight in her.  
My foot has pursued a straight path,  
I have sought her ever since my youth.  
By bowing my ear a little, I have received her,  
and have found much instruction.  
Thanks to her I have advanced;  
Glory be to him who has given me wisdom,  
For I was determined to put her into practice,  
have earnestly pursued the good, and shall not  
be put to shame."*

#### Notes:

1 After dinner speech, John Plunkett Centre Second Annual Intensive Bioethics Course, Manly, July, 1995.

2 Ben Sira, *Ecclesiasticus*, Appendices 51, extract from "Poem on the quest for wisdom".

3 Pope Pius XII, "The prolongation of life" (Nov. 24, 1957), *The Pope Speaks*, 4: no. 4, p. 320 (1958).

4 Pat Walsh, "Doctors in a minefield", *The Tablet*, 29 April, p. 529 (1995).

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# Bioethics - Trends in Canada: Part II

*Keith Joseph*

In the last issue, I addressed the issue of resource allocation in Canada. In this issue I want to turn to clinical ethics, which is an area where Canada has followed the United States model. In many ways this model is well in advance of anything that we have in Australia. The Canadian and American approach to clinical ethics stresses the role of ethicists working actively in the hospitals. Thus, for example, the centre which I visited in January this year (the Westminster Institute for Ethics and Human Values, at the University of Western Ontario) had two clinical ethicists who spent most of their time working in local hospitals. The city of London, Ontario, has medical facilities which serve a population of about 500,000 people and has two clinical ethicists. In Ontario, with a population of 9.9 million, there are more than twenty hospital based clinical ethicists. As far as I know, there are no persons in a similar position in New South Wales.

## Clinical Ethics

Clinical ethics appears to be given far greater emphasis in North America than in Australia. My impression was that clinical ethicists were highly respected by the doctors and nursing staff with whom they worked; they often accompanied the doctors and nursing staff on rounds and had a close working relationship with them. The two clinical ethicists in London were both women; one was an Anglican priest who was previously a biostatistician; the other was formerly a registered nurse who had since gone on to gain a Master's degree in theological ethics. The combination of medical and theological background was obviously beneficial in their work.

The procedures for the identification and resolution of ethical problems were well in advance of what we have in Australia. Hospital

staff are aware of the ethicists, and can raise with them ethical concerns that they may have. In turn, there is an institutional mechanism by which the ethicist may give voice to those concerns. There is thus a semi-formal structure for raising ethical concerns of a kind which we do not have in Australia, and which would be of great value. It is hard to imagine that the infamous cervical cancer experiments in Christchurch, New Zealand, could have occurred in London, Ontario, given the apparent awareness of doctors and other staff of ethics and of ways in which ethical concerns can be voiced.

However, there is the danger that by defining clinical ethics too narrowly - by concentrating on micro-management of ethical problems - that one will lose sight of the "big picture". Ethicists are likely to be called into the resolution of resource allocation dilemmas at the micro-level. For example: which very sick child gets admitted to the Intensive Care Unit when there are not enough beds? There is then the risk that other approaches to resource allocation may be ignored, leaving the ethicist dealing with problems which will never be resolved at the micro-level. Instead of asking why there are not enough beds, the ethicist will be confined to sorting out who gets the few beds that are available. The role of the clinical ethicist will then change from that of a resolver of ethical problems to that of a manager of them.

In Australia the idea of ethicists attending rounds is unlikely to be widely accepted, for a number of cultural reasons. However, the implementation of a semi-formal procedure within institutions for the resolution of ethical problems is an important step that would be of value in Australia. It would save recourse to legal or bureaucratic mechanisms, and would probably be of value in the quick resolution of ethical problems.

# Why voluntary euthanasia should not be legalised

Gerald Gleeson

Euthanasia is deliberately ending a person's life in order to eliminate all suffering.<sup>1</sup> The ultimate ethical question about euthanasia is whether it could ever be right - at a person's request - to hasten that person's death, i.e. to kill him or her, in order to end the person's suffering. This ethical question is distinct from the legal question as to whether the law should give a person the right to request euthanasia under certain circumstances, and/or to protect from prosecution someone who carries out another's request for euthanasia.

Even if euthanasia were ethically defensible in some circumstances - and this is a very big "if" - it would not follow that euthanasia should be legalised. We must examine the consequences of legalised euthanasia, in addition to the more fundamental ethical issue which such legalisation presupposes. The following considerations tell against legalised euthanasia:

## The role and force of the law

The law has an educative role: by legalising euthanasia our society would be "teaching" that under some circumstances it is right to kill another person. To "teach" this would be to weaken one of the central moral convictions of western civilisation.

Every law we make brings with it a certain presumption or bias towards what it seeks to protect: guilt or innocence, freedom or equality, individual liberty or community protection. For example, our criminal law requires that guilt, not innocence, be proved. This system of law protects the innocent, at the cost of the guilty sometimes going free. We have judged this to be the right presumption to act on.

The present law about killing protects the most vulnerable - the infirm, the aged, the impressionable, the lonely, the demented, the handicapped - from being killed. The present

law also recognises that medical treatment may be withheld or withdrawn if it is futile or overly-burdensome. The present law does not require life to be prolonged in circumstances which are unacceptable to the patient. To legalise euthanasia would be to undermine this protection of the vulnerable from being killed without their consent, in order to promote the freedom of a few people to end their lives when they so choose.

## The tendency to abuse the law

It may not be immediately clear why legalised euthanasia would inevitably lead to abuses whereby innocent people would be killed who ought not be killed. Proponents of voluntary euthanasia claim that their law will include two main safeguards:

First: euthanasia must be requested by the patient, so it won't be involuntary.

Second: it must be established that a person's request for euthanasia is soundly based, so no one will act on hasty or "unwise" decisions.

Further reflection shows that, no matter how tightly the law is framed, legalised euthanasia would foster the abuses of both involuntary euthanasia and inappropriate voluntary euthanasia.

## The move from voluntary to involuntary euthanasia

Much as proponents of legalised euthanasia emphasise the voluntariness of euthanasia, the focus of the legalisation, and most of its provisions, will be taken up with setting out the conditions under which a person's request may, or should, be complied with. These conditions concern both the person's state of health (terminal illness, pain and suffering, unacceptable quality of life, etc.), and the soundness of the person's request (informed consent, psychological stability, absence of pressure, time for reconsideration, etc.).

The first set of conditions rightly directs us not so much to the simple fact of a person's request, but to the conditions under which the law regards a request for euthanasia as legitimate (e.g. terminal illness with no hope for improvement). But a law which legitimates voluntary euthanasia in certain circumstances (e.g. terminal illness with no hope for improvement) thereby encourages the thought that euthanasia is also legitimate in the case of patients in similar circumstances even though they have not requested euthanasia or are incapable of doing so (e.g. because they are in irreversible coma).

Much as proponents of legalised euthanasia emphasise its voluntariness, what is critical to the decision to act on a patient's request is the condition of the patient, quite apart from their request. Indeed, will it be long before we hear the suggestion that not to euthanise "incompetent" patients would amount to unjust discrimination? Why should the "incompetent" be kept alive in circumstances in which the "competent" are allowed by law to end their lives through euthanasia? (Already we hear it said that the law discriminates against those who are unable to commit suicide!)

### **The move to undue compliance with requests for euthanasia**

The second set of conditions recognise that a person's request can be more or less soundly based. Not any and every request should immediately be acted upon. For example, a person may be giving up too soon, or may be wanting to punish others, or may be acting out of self-pity, or may be thinking (falsely) that he or she is just a burden to others, and so on.

But, despite its requirements for sound decision making, a law which legitimates voluntary euthanasia would inevitably promote a society in which requests for euthanasia would readily be acted upon. The presumption or bias of such a law would be towards accepting a person's request too easily, just because it was the person's request, rather than discouraging such requests altogether.

More worryingly, a law which "teaches" that it is right to request euthanasia would quickly

be seen to teach that one has a "duty" to request euthanasia (e.g. so as not to be a burden on others). We know that relatives and friends are often wishing a person would die. Legalised euthanasia would "legitimate" that wish, and create an environment of fear among those whose lives are drawing to an end.

Much as proponents of legalised euthanasia want to ensure the soundness of a person's request for euthanasia, their proposed law would in fact "teach" that any such request is likely to be sound, and should be respected and complied with, whereas a little knowledge of human nature suggests precisely the opposite. Indeed, will it be long before we hear the suggestion that those who are depressed or intellectually disabled have just as much right to "request" euthanasia as do those not so afflicted?

### **A law we cannot do without**

No civilised society can be without laws governing life and death, and the medical treatments which impact on life and death. No law can be without a presumption or bias about what it protects. In matters of medical treatment, the protection of life must continue to be our priority. Legalised euthanasia would alter this presumption: it would protect the freedom of a few to have access to voluntary euthanasia. It would no longer protect the vulnerable from having their lives ended without their consent.

We should retain the existing presumption because legalised voluntary euthanasia would inevitably lead to the euthanasia of those whose lives ought not be ended, both in the case of incompetent patients and in the case of competent patients whose requests are not soundly based. The dangers of legalising voluntary euthanasia are such that our law ought to protect the vulnerable from these dangers, even if this means restricting the freedom of those few in our society who want access to euthanasia.

1 For the arguments presented here I am indebted to John Quilter's paper, 'Against Legal Protection of Voluntary Active Euthanasia', *Proceedings of a seminar on euthanasia*, John Plunkett Centre, 1995.



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# Suicide, euthanasia and 'quality of life' considerations

Some comments about the model legislation to permit euthanasia proposed by the Aids Council of New South Wales

*Bernadette Tobin*

On May 1995 the Parliament of the Northern Territory legalized voluntary euthanasia.<sup>1</sup> Shortly afterwards, the Aids Council of New South Wales (ACON) published its own preferred model for legalizing euthanasia, entitled the "Voluntary Euthanasia Bill 1995". A member of the Upper House of the NSW legislature (Mr Paul O'Grady) then indicated that he would introduce a Private Member's Bill to legalize euthanasia when the NSW parliament resumes for its autumn session later this month.

Though it is not known how closely Mr O'Grady's Private Member's Bill will resemble the ACON model, the ACON proposal is worth studying in its own right, in particular because it goes much further than the Northern Territory legislation in introducing the idea that a lack of 'quality of life' is a sound reason for requesting, and for performing, euthanasia.

ACON describes its model legislation in the following way. It allows people who are over 18 and who are of sound mind to end their lives with the help of medical practitioners. The Bill protects doctors who help in the way specified in the Bill from criminal prosecution or disciplinary proceedings for their role in 'helping the person to die.'

In commenting on the provisions of the ACON model legislation, I do not intend to compare it with the Northern Territory legislation (except incidentally). In my view there is no way you can legalize voluntary euthanasia without at the same time opening the way to nonvoluntary and involuntary euthanasia in the short to medium term. That is to say, there is no safe way of legalizing voluntary euthanasia. And even if one could build in the 'appropriate' safeguards, there is no reliable way of ensuring that the 'safeguards' will be effective in practice. If this is so, there is little point in comparing and contrasting relative strengths

and weaknesses of proposed or actual legislative arrangements for permitting euthanasia. If the goal of the legislation is itself socially unwise and inhumane, if 'safeguards' will be ineffective in practice, there seems little point in trying to work out whether one proposal to bring it about is 'better' or 'worse' than another.

That said, two features of the ACON model legislation deserve special attention: first, the fact that it goes much further than the Northern Territory Act in the grounds it proposes for permitting euthanasia, and second the fact that it conflates two distinct human acts: suicide and euthanasia.

## Quality of life as a ground for requesting euthanasia

The Northern Territory Act specifies that there is only one class of person whose request for euthanasia may be acted upon: that is, people who are terminally ill. The ACON model legislation proposes that there should be two classes of people whose request for euthanasia may be acceded to.

In addition to a person who 'has a terminal illness', a person who has an 'unacceptable quality of life', who

*'(i) has a serious physical condition or serious physical illness which causes her or him unacceptable pain or distress, and (ii) has been advised by a medical practitioner that the medical practitioner is of the opinion that the serious physical condition or serious physical illness is unlikely to improve significantly with the administration of treatments reasonably available and acceptable to the person, and (iii) has been advised by the medical practitioner that the medical practitioner is of the opinion that the person is unlikely to experience a significant improvement in the way in which she or he experiences her or his quality of life'*

may

*'request the medical practitioner to assist her or him to end the person's life'.*

Proposals to legalize euthanasia almost always insist that the only requests for euthanasia which may be acted upon are those that come from people who will in the short term die from their illness (the so-called 'terminally ill'). This is presumably intended to allay fears that its legalization would lead to widespread killing. It has been pointed out often enough that (for instance) a diabetic who for whatever reason stopped taking her insulin would thereby become 'terminally ill' and qualify for euthanasia. So too would someone with polio who decides that she is tired of going on a ventilator at night. There are, that is to say, very good reasons for being sceptical about the claim that confining the scope of legitimate requests for euthanasia to those who are 'terminally ill' will act as any kind of safeguard at all.

But the Aids Council of New South Wales proposes that we abandon even this 'safeguard', that we give legal protection to a doctor who accedes to a request for euthanasia from someone who, as a result of suffering from a serious illness, 'has an unacceptable quality of life'.

It should be obvious just how much wider this would make the scope of legally-protected requests for euthanasia. One could imagine someone who becomes paraplegic through a car accident requesting euthanasia because he is distressed not so much by his disability as by the way in which other people respond to him as a disabled person. Or a young woman distressed not only by her anorexia nervosa but also by whatever causal factors led to her suffering this illness. And indeed, as Karen Clarke has pointed out, one could envisage circumstances in which a pianist who lost his right arm, and who was (understandably) distressed about this, might request euthanasia.<sup>2</sup> Such people would qualify for euthanasia under the ACON proposal.

Does this extension of the class of legitimate candidates for euthanasia matter? Certainly it adds immeasurably to a concern about the social effects of legalizing euthanasia. In the space of a few weeks we have witnessed in Australia a slide from enacted legislation which requires that a person requesting euthanasia be terminally ill to proposed legislation that would make it

legal to provide euthanasia for someone who is merely dissatisfied with the quality of his or her life. That swift slide shows just how unsafe it is to breach our age-old prohibition against killing each other. Once we abandon that prohibition for one category of persons (those who are terminally ill and request euthanasia), the idea emerges that others (in the ACON proposal, those who have a serious physical illness and request euthanasia) have a legitimate 'right' to the same thing.

It is utterly predictable that someone will soon claim that there ought to be a third category of people who may legitimately request euthanasia: those whose dissatisfaction with their lives is not associated with any illness at all. It is therefore not surprising that recently both a Select Committee of the English House of Lords and a Taskforce on Life and the Law chaired by the Governor of New York State came to the conclusion that there was no safe way of legalizing euthanasia.

#### **Failure to distinguish between suicide and euthanasia.**

Although the ACON proposal is called a 'Voluntary Euthanasia Bill', the literature which accompanies the proposed Bill consistently talks of 'providing help' to someone who 'wants to end their life'. The long title of its proposed Bill is:

*'An Act to confirm the right of certain persons to request assistance from a medically qualified person to voluntarily terminate her or his life in a humane manner; to allow for such assistance to be given in certain circumstances without legal impediment to the person rendering the assistance ...'*

The Bill defines 'assist' and 'assistance' to include not only

*'the prescribing of a substance for the person to administer to herself or himself, the preparation of a substance for administration'*

but also

*'if the person is not physically capable of administering it, also the administration of the substance.'*

That is to say, the Bill ignores the distinction

between suicide and euthanasia, between killing oneself and killing another person in order to relieve suffering.

The starting point for such conceptual confusion is, presumably, the case of 'assisted suicide', that is to say, a case in which someone helps another person to take his own life. No doubt it will sometimes be difficult to say whether such a death is best described as 'suicide' or 'euthanasia', just as it may be hard to say whether a moment at dusk is best described as day-time or night-time. Some 'bringings about of death' are borderline between suicide and euthanasia.

However, the fact that there may be borderline cases does not give us any warrant to deny the distinction itself. Some deaths, whatever one thinks about their ethical status, are clearly and unambiguously the killing of one person by another. The age-old prohibition on which our society is (in part) based is the prohibition on our killing each other.<sup>3</sup>

Some of those who recommend the ACON proposal speak of it as essentially a procedure for helping (or, in the current jargon, 'empowering') an individual to take control over his own life and death, helping a person to be the active agent in his own death. But the proposed Bill in fact would go much further than that. It would legalize someone else becoming the active agent in that individual's death: one person killing another at the request of the former.

This 'asymmetry' between suicide and euthanasia matters.<sup>4</sup> Differences of agency matter. That is to say: it matters who brings about death, the person who wants to die or another person. The reasons which may lead a doctor to think he is justified in performing voluntary euthanasia are not exactly same as those of a patient who thinks he is justified in committing suicide. The patient's reasons for considering suicide will be that (for instance) he is very depressed about his life, that the condition in which he lives is intolerable, that he is a burden on his family or 'caregivers', that his life is empty and meaningless, etc.

But the doctor's reasons for considering performing voluntary euthanasia will include a further reason: the fact that a patient requests him to bring about his death. This difference is important. The doctor will have to take

responsibility for what he does. His patient's reasons for wanting to commit suicide will not necessarily be enough for him to conclude that that he is justified in performing euthanasia on that person. He has to make up his own mind about whether he is justified in helping to bring about that person's death. He is much more than an instrument or *manus ministra*: he is an independent moral agent who has to decide for himself the rightness or wrongness of his own actions.<sup>5</sup>

Why does the Aids Council of New South Wales blur the distinctions between suicide, assisted suicide and euthanasia? They do so, I suggest, because ACON recognizes that the agreement not to kill one another (even at the request of the other) is one of the fundamental social institutions which shapes our society. Rather than confront that prohibition, rather than try to defend the claim that killing someone in the circumstances described in the Bill constitutes a morally-permissible exception to that prohibition, they simply redescribe the killing of one person by another in those circumstances (among them: at that person's request) as *his taking his own life* with assistance of someone else if necessary.

Blurring the distinctions between suicide, assisted suicide and euthanasia, treating them all as if they were cases of (more or less unaided) suicide fosters a cast of mind which focuses us away from the fact that what is proposed would be a fundamental change to the age-old prohibition on killing each other. This is perhaps good strategy: it is certainly poor philosophy.

#### Notes:

1 Similar legislation had been passed by the Oregon State Legislature in the United States last year. However, Oregon's 'Dying with Dignity' Bill was found to be unconstitutional by a United States Federal Court in August this year on the grounds that it denied equal protection of the law to the terminally ill and the disabled.

2 Legalizing Euthanasia: the Australian Experience', Talk given at a Seminar on the Sanctity of Life, University of Tasmania, 12th August 1995

3 Exceptions have been made for killings in self-defence: war, capital punishment and other acts of self-defence.

4 John Quilter uses this expression in his paper entitled 'Against the Legal Protection of Voluntary Active Euthanasia', *Proceedings of a seminar on euthanasia*, John Plunkett Centre, 1995, p 25.

5 Professor Rummelink, 'The Legal Position of Euthanasia in The Netherlands', *Proceedings of a Seminar on euthanasia*, John Plunkett Centre, 1995, p 8.

# NOTEBOOK

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

Australian Catholic University is inviting applications for the academic year 1996 for fee-paying programmes in Applied Ethics (Health Care).

The Graduate Certificate is especially developed for professional staff in the area of Health Care who have had no opportunity for formal study of ethical issues.

The Master of Arts is a programme especially designed for those with leadership roles in medicine, nursing, social work and health care administration.

Both programmes provide opportunities for a critical and reflective interdisciplinary study of practical ethics. They aim to equip students to engage in reasoned and well-informed debate on the ethical issues arising from their professional work. The programmes consider the range of ethical perspectives and religious traditions that inform ethical decision making in contemporary Australia.

For further information, please contact Dr Robert Gascoigne, Course coordinator, on (02) 739 2193, or the School of Religion and Philosophy, Australian Catholic University (NSW) on (02) 739 2252.

### Seminar Proceedings Available

There are still copies available of the proceedings of the seminar on euthanasia which was held under the sponsorship of the John Plunkett Centre for Ethics in November last year. Speakers included Professor Rummelink of the Netherlands and Mr John Quilter of the Centre. Copies are available at a cost of \$15.00, including postage (\$10.00 for Associates of the Centre). For further information ring Barbara Reen on (02) 361 2869.

## L. J. Goody Bioethics for Nurses Association

As a result of many enquiries from nurses, the enthusiasm of Daria Koutsoukos and with the support of Fr Walter Black, MSC, the L. J. Goody Bioethics for Nurses Association held their Inaugural General Meeting on Friday 25 August 1995. Ms Heather McAlpine, Lecturer and Coordinator of the Ethics Unit, Edith Cowan University, spoke on *Why a Nurses' Bioethics Association?*

The Association is there to listen to the needs of nurses in this area and to provide a dual role of education and support. Members of the executive and working party are nurses, and membership is open to all nurses. As technology and societal attitudes change, nurses need continuing information and support to be empowered in their position of patient carers.

Issues gleaned from the Inaugural Meeting will be the focus of the first education session on 14 November 1995.

Further information may be obtained from the L. J. Goody Bioethics Centre, 39 Jugan Street, Glendalough, WA 6016. Telephone: (09) 242 4066; Fax: (09) 242 4067.

### Advanced Bioethics Course

Registrations are now open for the Centre's first Advanced Bioethics course, to be held at the Ave Maria Retreat Centre in Point Piper, Sydney, on the weekend of 6 - 8 October. The theme of this course will be "Christian Contributions to Contemporary Bioethics." For further information ring Barbara Reen on (02) 361 2869.

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