

Caroline Chisholm Centre for Health Ethics

NEW CENTRE LAUNCHED

The Caroline Chisholm Centre for Health Ethics came into operation in March 1995 as a response by Catholic Hospitals to the demand for improved understanding and advice on the emerging ethical issues in health care. It follows on from the prestigious St Vincent's Bio-Ethics Centre which had been established in the 1980's by the Sisters of Charity.

In the early nineties many hospitals saw the need for wider questions in health ethics to be examined expertly from a Catholic perspective. Talks were held between the Sister Administrators and Chief Executive Officers of St Vincent's Public and Mercy Public Hospitals' and ethical experts to explore the possibility of a new cooperative centre.

In October 1993 a meeting was held at St Vincent's Hospital, chaired by Dr David Campbell, Chief Executive Officer of St Vincent's and attended by a number of hospital representatives and ethics experts.

In early 1994 a working party was established to investigate the need for a new Centre and to recommend its nature, purposes and organisational structure.

Initially centred around the Catholic public hospitals, Catholic private hospitals soon became interested in such a centre.

Bishop Connors joined the working party and a representative of the Australian Catholic University attended to help in the examination of ways in which the Centre might

collaborate with that new academic institution.

Contact was maintained with the Archbishop of Melbourne and finally a Constitution and Rules were adopted by members of the participating hospitals. The Centre was legally established under the Associations Incorporation Act 1981 on 20 Dec. 1994.

The institutions who founded and finance the Centre are listed later in the Bulletin, as well as the purposes for which the Centre was established.

Rev. Dr. Norman Ford SDB, an internationally known philosopher and moral theologian was appointed the Foundation Director and took up his position in March.

The Centre was blessed by Archbishop Little on May 8th 1995. On that occasion Archbishop Little augured the Centre would live up to its "responsibility to be true to the purposes of its establishment as a Catholic voice in health ethics in Victoria. ... I foresee that the Centre will provide responsible leadership and will be a focal point for all who wish to promote the **Gospel of Life** in public life. Happily I look forward to the Centre expounding the underpinnings of Catholic moral teaching in relation to health ethics".

The Centre was publicly launched on July 20th with a discussion on euthanasia. Thought provoking talks were given by the Fr Ford, Dr Helga Khuse and Dr Peter Beaumont,

while Professor Louis Waller superbly summed up the session.

The Centre has begun its search for truth and looks to Caroline Chisholm for inspiration and determination in its work.

This Bulletin will be an important outreach for the Centre. Its articles will be short, but solid, readable and directed to informed persons seeking moral truth in health ethics in the Christian and Catholic traditions. ✚

Mr Joe Delaney

*Chairperson of the Board of Management
of the Centre.*

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CAROLINE CHISHOLM

The choice of Caroline Chisholm as the name for the Centre was made after much reflection on the story of her life. Three features stand out in that story: her commitment to help in a real way those people without direction or purpose; her strong pursuit for social order by addressing the underlying problems of society; and her dedication to family life.

The bare statistics of her C.V. reveal little of the person. Caroline Jones was born in Northampton, England in 1808; married at 22 years, to Scottish highlander Archibald Chisholm, aged 35; 4 sons, 2 daughters; died at the age of 68 in poor circumstances; buried in the Billings Road Cemetery, Northampton, England.

There is nothing here to point to her idealism and courage, her executive ability and personal charm. Reared in the tradition of Evangelical philanthropy, it is said that a condition of her marriage was that her philanthropic work would continue. But she was more than a philanthropist. During her seven years in New South Wales she was a social reformer and advocate, lobbyist and organiser.

Responding to the inhuman conditions experienced by migrant women she established houses of refuge, founded and operated employment registries and agencies

and ran, in effect, a social research centre. She was said to be a soft-voiced woman with serene grey eyes who started out working within established conventions, but when frustrated by officialdom, her attitude began to harden and she became an uncompromising radical.

The London Punch referred to her as a “second Moses in a bonnet and shawl” as she journeyed throughout the Bush and settled 11,000 people on the land. During these travels, a larger vision of immigration and a theory of colonization were developing in her mind.

Returning to London she enlisted the help of Charles Dickens and Earl Grey, the Colonial Secretary, and wealthy London merchants. She published statements, gave evidence to the House of Lords Committee and ensured passage of the Passenger Act 1852, which was intended to improve migrant ship conditions.

She also had established the Family Colonisation Loan Society to help families settle on land in the Australian Colonies. She became one of the most famous women in England and inspired Florence Nightingale in her work for the sick.

Back in Melbourne with her husband and family in 1854 she pursued land reform and improved conditions for families in the gold

fields, and even extracted 5,000 pounds from the Victorian Legislative Council towards her Loan Society, a princely sum in those days.

She was then struck down by a kidney disease which eventually proved fatal. She had given her health as well as her wealth in the service of others. Underlying all her work was a commitment to the dignity of the human person as a transcendent being, a dignity which is inherent in the person and not something that is given by society or taken away through legislation.

In the mid-part of the 19th Century Caroline Chisholm influenced society to protect the dignity of women particularly. The challenge of our Centre is to influence our society to enhance the dignity of the human person in the context of the particular circumstances which we face at the end of the 20th Century.

If we can do this, we will have earned the right to call ourselves the Caroline Chisholm Centre.✚

Mr Joe Delaney

Extract from talk at the Launching of the Centre on 20 July 1995.

Agreement with the Australian Catholic University

The Caroline Chisholm Centre has signed an agreement with the Australian Catholic University to the effect that each body would collaborate in joint projects relating to health ethics. Its purpose is to encourage education and research in the field of health ethics; to support undergraduate and

postgraduate education in health ethics in Victoria and to foster the sharing of staff and other resources. Joint operations will be determined and controlled by a Joint Steering Committee comprising the Chairperson of the Centre’s Board of Management, its Director and two nominees of the Vice-

Chancellor of the University. The Vice-Chancellor has nominated Professor Wolfgang Grichting and Dr Bernadette Tobin to the committee. ✚

IS EUTHANASIA MORALLY PERMISSIBLE ?

Gift of human life

Life is a special gift from our parents and God. He fashions us into persons by reason of the spiritual life-principle or soul that is God's unique creation in the whole of nature. Persons are designed and created to live forever, but only for a short time in this world. Life cannot be refused like other gifts because we do not exist prior to receiving it.

Life is a condition for the morally responsible use of reason and freedom. As rational creatures we should respond by gratefully accepting and cherishing the gift of life. It is a basic value for all, believers and non-believers alike. It provides an opportunity for all to live in an authentically human way. The gift of life is a challenge to become the sort of persons we are capable of becoming through love of God and neighbour.

Natural laws, freedom and death

Life and death are governed by natural laws to which we are physically, biologically and psychologically subject. It is natural for a well nourished person living in a suitable environment to be healthy.

Free acts, including the practice of medicine, may be viewed as interventions in the course of nature to combat disease, improve our health or raise our standards of living. Through free actions we show our transcendence over nature, changing the direction and/or sequence of the natural course of events. It is as natural for some drugs to cure sickness as it is for poisoned food to cause death. But it is not natural for poison to be found in food destined for human consumption. This would normally be explained by the abuse of

freedom.

Without prejudice to the exercise of our freedom, God determines our life-span in accordance with the design of natural laws. Life on earth ceases at the end of the process of dying. Death is the loss of the natural potency to live due to many factors, including the influence of the environment and our freely chosen lifestyles, e.g. eating, drinking, smoking, sleeping and working habits. Death marks the end of one's time for determining one's destiny by acting freely as a moral agent -- and we have no grounds for believing otherwise. Finally, death is always significant for one's family and the community.

Inviolability of human life

It is clear human life is morally inviolable. This excludes suicide and helping another commit suicide. Both are contrary to reason and the dignity of the person. The same applies to deliberately terminating the life of another upon request for compassionate reasons. Pope John Paul II in his recent Encyclical **Evangelium Vitae** defined euthanasia as "an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering". Some people, however, believe suicide and voluntary euthanasia are morally permissible. It does, however, seem morally odd to use one's freedom to terminate one's existence as a moral agent.

Duty of reasonable care

We are morally bound to use our freedom to take reasonable care of ourselves and others, especially the sick and the dying. This does not mean we are bound to go to unreasonable lengths in the circumstances to provide medical treatment to preserve life. The

frail, the elderly and the terminally ill should always be provided with the medical treatment appropriate for their condition. A point may be reached when medical treatment becomes too burdensome and, in certain circumstances, may be discontinued. It is unethical to choose to prolong a suffering patient's dying process. Provided normal nursing care is always given there is no moral duty to continue treatment that is not objectively proportionate to the prospects for the sick person's improvement.

Refusal of burdensome treatment not euthanasia

Clearly, foregoing burdensome or futile treatment is not euthanasia since the intention is not to cause death but to accept the human condition in the face of death and to avoid wasting scarce resources.

foregoing burdensome or futile treatment is not euthanasia

Withholding or withdrawing unwarranted medical treatment is simply allowing nature to take its course -- to let the dying process proceed unimpeded. The rule of thumb that everything possible to preserve life should be done made sense decades ago, but not today, with our sophisticated medical treatments and advanced technology for the preservation of life. There is nothing wrong with wanting to die a natural death to go to Heaven.

Pain control

For the first time in history medicine is now able to control the suffering of the dying. Palliative care makes the experience of pain

and suffering in the dying stages of life more bearable. It ensures the dying are given all the support and comfort they need, including pastoral and spiritual assistance. Contrary to some people's impressions, the medically supervised use of drugs to control pain in palliative care is not life threatening.

Pope Pius XII in 1957 spelt out Catholic teaching when he said it is morally permissible to "relieve pain by narcotics, even when the result is decreased consciousness and a shortening of life, if no other means exist, and if, in the given circumstances, this does not

prevent the carrying out of other religious and moral duties." Foreseeing death will result from the use of pain killers for a distressed dying newborn baby is not morally the same as giving a lethal injection with the intention of causing the baby's death.

Autonomy limited by respect for innocent human life

Life enables us to enjoy so many things from sport, music, the arts and cinema to cultural activities. Life itself is a priceless good and is worth living. Our personal autonomy is a great value which all should respect. It is our capacity

for freely governing ourselves and is co-terminus with human life. Autonomy, like conscience, pertains to our dignity and is an extremely important, but not an absolute, value. The recognition of duty represents a summons served on human autonomy to comply freely with the demands of morality. The moral law, however, prohibits absolutely and universally the intentional taking of innocent human life.✝

Dr Norman Ford SDB

COMMENTS ON VICTORIA'S INFERTILITY TREATMENT BILL

In the main it is not expected to have general agreement on Acts of Parliament, as these apply to all regardless of a person's religious, cultural or other affiliations (the one exception being for a conscientious objection in specific instances); yet a degree of consensus was reached on a Bill for the Infertility Treatment Act [to supersede the Infertility (Medical Procedures) Act 1984] which passed without amendment through both houses of the Victorian Parliament on June 7 1995. This Bill had bipartisan support. Even so there were expressions of disquiet on specific Clauses during the debates preceding the voting.

Features of the Infertility Treatment Act, 1995 are in:

- ⌘ *the inclusion of Guiding Principles,*
- ⌘ *an aim at clarity in the wording and comprehensiveness in its provisions,*
- ⌘ *a restriction to married couples regarding access to treatment procedures,*
- ⌘ *legal safeguards including a ban on surrogacy and strict regulations regarding research,*
- ⌘ *the enabling of a person born of a*

donor treatment procedure to receive identifying information about the donor, and
 ⌘ *a stress on information, counselling and consent.*

This is the first of two articles to discuss significant features of the Infertility Treatment Act and related ethical and moral issues.

The Inclusion of Guiding Principles

The inclusion of Guiding Principles makes the Infertility Treatment Act (hereafter referred to as the Act) distinctive, as these are not usually included in an Act of Parliament. In descending order of importance these principles are:

- (a) *the welfare and interests of any person born or to be born as a result of a treatment procedure are paramount;*
- (b) *human life should be preserved and protected;*
- (c) *the interests of the family should be considered;*
- (d) *infertile couples should be assisted in fulfilling their desire to have children (Clause 5).*

These principles are a guide in community responses to infertility. Of specific note is the hierarchical arrangement of the principles, with first priority being given to the welfare of children, born or to be born of an infertility treatment procedure. Consideration is to be

The welfare and interests of any person born or to be born as a result of a treatment procedure are paramount

given next, to the preservation and protection of human life. This principle takes into account the life of a child born of a treatment procedure, i.e. in the avoidance of practices or research likely to harm a child. It also takes into account the lives of participants in these procedures, i.e. in avoiding over-stressful treatments, or those threatening the well-being (including the emotional and spiritual well-being) of a woman or man taking part in them. Following on, consideration is to be given to the interests of the family. Children

and parents develop their lives, not in isolation, but by interacting with each other within the parameters of a family unit.

Family interests include an ability to provide for the care and nurture of a child to be born into the family, and existing family responsibilities and obligations. Fourthly, infertile couples have no need to feel embarrassed nor of lesser worth because they are unable to bear children but are entitled to receive support and assistance from the community in their desire to become parents.

It is

The interests of the family should be considered

worth noting that in assigning first priority to the welfare of children the Guiding Principles focus attention on what the Act is all about, i.e. facilitating the birth of children. Sharing in some way in enabling the birth of a child is at the very essence of procedures to relieve infertility; yet children are more than a biological result of a medical technology. Each child is unique and of inestimable worth. To play a part in bringing a child to birth is to share in a creative power (to believers in the divine power of God) and this brings responsibilities, on the part of those who provide these services and on the part of those who participate in them.

An aim at Clarity in its Wording and Comprehensiveness in its Provisions

More so than did the 1984 Infertility (Medical Procedures) Act the Act aims at being clear in its wording. To assist here is a list of definitions. The previously undefined word "embryo", for example, caused confusion and hindered what otherwise could have resulted in beneficial discussion.

Hopefully the clarifications will facilitate exchange and debate. Among the words clarified in the definitions are:

embryo - (which) means any stage of embryonic development at or from syngamy;

oocyte - (which) means an ovum from a woman but does not include a parthenogenetic oocyte;

parthenogenesis - (which) means cell division in an oocyte which only involves the chromosomes of an oocyte; (parthenogenesis involves activation of an egg without fertilisation by the sperm).

syngamy - (which) means that stage of development of a fertilised oocyte where the chromosomes derived from the male and female pronuclei align along the mitotic spindle; (syngamy takes place at about 22 hours after the beginning of the penetration of an oocyte by a sperm).

zygote - (which) means the stages of human development from the commencement of penetration of an oocyte by sperm up to but not including syngamy (Clause 3).

Infertility treatment procedures are intended to be used only as a last resort; yet the wording of the Act is comprehensive so as to accommodate different circumstances among those wishing to avail themselves of them. A couple presenting for an infertility treatment must undergo an assessment to enable a medical practitioner establish that the woman is unlikely to become pregnant other than by a treatment procedure, or if she did become pregnant other than by a treatment procedure a disease or genetic abnormality is likely to result in a child so born.

A waiting period of twelve months required under the previous regulations is omitted and provides for instances where the requirement would be futile, for example where a woman has no ovaries or where a

man cannot produce sperm.

Human life should be preserved and protected

Also omitted from the previous Act is a requirement that a woman before undergoing a treatment procedure be examined by a second doctor (Clause 8). There have been expressions of concern that this relaxing of previous requirements may lead to abuse. But adherence by a medical practitioner to the conditions of his or her licence should ensure this is not so.

A Restriction to Married Couples Regarding Access to Treatment Procedures

At the same time the Act is regarded as being conservative. It restricts access to treatment procedures to married couples. This was also the case with the previous Act and has elicited strong expressions of disquiet from some who profess they will continue lobbying to have treatment procedures available also to de facto couples. Without doubting the sincerity of these claims there are nevertheless related issues to be kept in mind. A parental undertaking, in its task of nurturing children, is supported - as in its other functions - by the legal commitment of a couple to each other. Personal strains additional to those normally felt on a couple's relationship are known to be associated with infertility treatments. This can result, where the couple do not have the support of a marriage commitment to each other, in further tension on each partner, leaving each more prone than otherwise to end an unstable or fragile relationship, and this whole process is un conducive to the welfare of their children.

The availability of a donor treatment procedure is further

limited again, and may not be resorted to unless:- a) a woman is unlikely to become pregnant other than by a donor treatment procedure, or b) if she did become pregnant other than by a donor treatment procedure a genetic abnormality or a disease is likely to result in a child so born.

Legal Safeguards including a Ban on Surrogacy and Limitations on Embryo Experimentation

In line with agreement reached through extensive consultation with State and Territory Health and Social Welfare Ministers, Church and Children's Services professionals the Act continues to prohibit, as did the 1984 Act, commercial surrogacy and stipulates that a surrogacy agreement is void (Clauses 59-61). These clauses uphold the intention of the Act to place the interests of children first. Each child has a right to an unambiguous concept of his or her identity.

In a surrogacy arrangement there can be several people each claiming a title of parent; and there is ample documentation on the anguish many a surrogate mother has gone through in relinquishing a child she gave birth to. Some claim there is something benign about an altruistic surrogacy. Yet it has been shown an altruistic surrogacy can in effect be more demeaning to a woman than a commercial surrogacy where, if she is not satisfied she can tear up the cheque or hand back the money. This is not possible with an altruistic surrogacy. Within the controlling expectations of family mores it can be virtually impossible for a woman to refuse a surrogacy request and be left with no bargaining power, no one to turn to for support (her family being her accusers), nor legal nor other means of redress. Children born and growing up in such an atmosphere can scarcely avoid being caught up in this unpleasantness.

There are some groups, quite apart from religious affiliations, who from their experiences in working with children speak not only against surrogacy but against donor treatment and other forms of assisted conception, claiming these are detrimental to the integrity of the women who participate in them and to the rights of a child, who in these instances, it is said, comes to be looked on as a commodity. This may be an extreme view, but the possibilities for excess in having recourse to infertility treatments need to be kept in mind.

Infertility procedures should be used only as a last resort

The Act places strict conditions on research. All research must have the approval of the Infertility Treatment Authority, which will be guided in its approval or refusal of applications by the advice of the Standing Review and Advisory Committee on Infertility. Embryos must not be created for the purpose of research, but for transfer to a woman. Destructive research on embryos is forbidden. Research on an embryo can take place only on condition the research does not harm the embryo, nor make the embryo unfit for transfer, nor reduce the likelihood of a pregnancy resulting from transfer of the embryo. These restrictions reflect a lessening of a need for research on embryos owing to rapid advances made in molecular biology. Scientists now can develop specially constructed DNA probes to detect mutant genes in human cells. A mutant gene is one with characteristics not evident, but hidden, in a person carrying the gene, but which characteristics may be passed on to that person's children. By examining the DNA sequences in human cells certain genetic abnormalities carried by either or both intending parents can now be detected before fertilisation takes

place. From this, the likelihood of a couple bearing a child with a genetic abnormality can in many instances be discerned by examination the couple's sperm and oocytes.

While the Act, in forbidding destructive research on embryos, is more strict than was the 1984 Act, the Act (1995) provides a wider scope for embryo biopsy than was allowed for previously. A biopsy is the removal of one cell from a four or eight cell developing embryo for microscopic examination. These provisions (in the 1995 Act) provide further assistance to couples fearful of passing on a genetic related abnormality or a disease, and make allowance also for the prevention of a disease that may not be genetically related, ie. a disease passed on in the seminal fluid. There is a need for continuing debate on the ethics of embryo biopsy.

Research for sex selection is prohibited, except where a child's sex may be related to a genetically inherited disease. A zygote may be created for the purpose of research, including destructive research; however, research on a zygote must cease before syngamy. Research involving parthenogenesis can be carried out only with the approval of the Authority. For all research, whether on gametes, zygotes or embryos there are strict requirements regarding consent (of those who produced the gametes, zygotes or embryos and the consent of the spouses of these people [Clauses 22-38]). Associated with research is the ethical question of disabled children, the welcome and care due to them and the avoidance of discrimination against them. These are issues beyond the scope of the Act and also of this paper; nevertheless they need to be taken up.

There are several prohibited procedures under the Act. A person may not alter the genetic constitution of a gamete, zygote or

embryo, except to alter the somatic cells for therapeutic purposes. Nor is it permissible to transfer gametes, zygotes or embryos used for research. There are a number of bans listed in the Act: - on the use of gametes produced by children; on the use of oocytes derived from a foetus; on the use of gametes from people known to be dead; on the use of zygotes or embryos removed from the body; on mixing human and animal gametes; on mixing gametes, zygotes or embryos from more than one person; on cloning; on sex selection and on certain experimental procedures. Zygotes and embryos may be formed only in accordance with the Act (Clauses 39-50).

It is prohibited to bring into Victoria or to take out of Victoria gametes, zygotes or embryos except with the approval of the Authority (Clause 56). Both the 1984 and the 1995 Acts forbid a donor to receive payment for his or her services except to cover related medical or travelling expenses.

The Act addresses the storage and disposal of gametes, zygotes and

embryos. As the 1984 Act made no provision for disposal there has amassed over the years several thousands of embryos which are currently held frozen in storage. The Act (1995) limits the period for which gametes may be stored to ten years and the period for the storage of zygotes and embryos to five years - unless by explicit approval of the Authority. People who produced stored gametes, zygotes or embryos may opt for a shorter storage period.

Infertile couples should be assisted in fulfilling their desire to have children

Gametes, zygotes and embryos must be stored at licensed premises (Clauses 51-55).

Some response on the part of Parliament to this issue, i.e. in limiting the length of storage time of gametes zygotes and embryos, has been long overdue and the decision seems appropriate. However, to agree with this

decision - which is a response to circumstances already established - is not to condone the creation and storage of frozen embryos in the first place. ❖

Dr Mary C. Stainsby RSM

Research Officer of the Centre
(This discussion will be concluded in the next edition of the Bulletin)

EUTHANASIA - DOCTORS' DILEMMA

I would like to give an opinion from the "doctor in the street" on whether euthanasia should be legalised. But before I do that, I must say that in the past year I have discovered that ethicists have an entirely different role in our society than I originally perceived. I thought that their role was to act as conciliators, to assist society, or sub-groups of society, to gain a consensus on moral and ethical views. Quite clearly this is not the case. From what I have seen, their role is to determine what they think are the correct ethics or morals and attempt to persuade society to accept them. You might well ask, as I did, "Why has Reverend Dr Norman Ford

invited Peter Beaumont here tonight?". As President for the Victorian Branch of the Australian Medical Association, I was in a position to understand the feelings of many doctors concerning euthanasia and able to present these on behalf of it. Although I will be referring to the AMA and its policies tonight, I do not represent the Association here. Even if I was still President, I would not have chosen to accept the invitation to speak here if I didn't also have a personal interest in the issue.

I believe that my life experiences stand me in good stead to discuss euthanasia. Those experiences

include 14 years in private general practice, the devastating personal and family experience in caring for my first born daughter through four years of leukemia to her death in 1980 in an irretrievable relapse at six years of age. My experience and interest in palliative care are fostered by people such as Norelle Lickiss of Royal Prince Alfred Hospital in Sydney and Ray Lowenthal in Hobart who played prominent roles earlier in my career. I have also worked in palliative care and hospices on several occasions. The debate on euthanasia in our society has basically been brought about through changes that have occurred in the space of a

generation, where autonomy has overcome beneficence as the overriding principle guiding medical practice.

This preminence which society now places on autonomy has brought people to question the long standing basis of medical ethics and its application to individual cases in our society.

On top of this basic change, the debate has been fuelled by a perception that euthanasia is legal in Holland, a perception which is incorrect as actions of euthanasia in that country are not protected by the law, but result in reports to a coroner and then to a public prosecutor who has the power to decide whether to turn a blind eye on the event or act upon it.

Any debate on euthanasia is very difficult as individuals in our society usually have very fixed views which have been engendered through many mechanisms throughout their lives, including religious beliefs, family and peer views, education and an understanding of what is available for the relief of suffering.

Some people have led the debate into a tangent, discussing the meaning of euthanasia, differences between active, passive, voluntary and involuntary euthanasia, some have even postulated that there could be a compulsory form. But don't be mistaken about its official meaning or derivation - euthanasia means the killing of a person to relieve suffering.

And perhaps it wouldn't always be the patient who was suffering. John D Buchanan writing in the Age on Tuesday 28 March this year, pointed to the hopelessness of failing to relieve suffering when he said, "Any solution which can only cope with the suffering of a person by the elimination of the patient seems a very poor solution".

It is impossible to present the doctors' collective view on euthanasia as doctors' opinions in

this regard are as wide and as entrenched as are the opinions of the many people who have expressed their views in the media in the recent months.

Don't be mistaken about its official meaning:- euthanasia means the killing of a person to relieve suffering

I welcome a forum such as this to discuss euthanasia for I do believe that it is an issue which must be discussed in our society so that people become fully informed and educated as to the factors surrounding it.

I do not agree fully with Professor Martin Van Der Weyden who, in the **Medical Journal of Australia** on the 5 June said "Active euthanasia should be widely discussed in an open forum free of the polemics of opponents and advocates, and without the political, religious and legal prohibitions that have stifled the debate".

My disagreement is that those religious, political, legal and other prohibitions are the basis of the framework of most peoples' personal ethics and morality and need to be taken into account in any debate.

The Australian Medical Association is opposed to euthanasia. At its recent National Conference in May of this year, the Association reconfirmed its stance on the appropriateness of the World Medical Association statement which reads:

"Euthanasia, that is, the act of deliberately ending the life of a patient, either at his own request or at the request of his close relatives, is unethical. This does not prevent the physician from respecting the will of a patient to allow the natural process of death to follow its course in the

terminal phase of sickness".

I apologise on behalf of the World Medical Association for the gender bias in the statement which was developed before the present sensitivities.

Further, the AMA Code of Ethics states: "Always bear in mind the obligation of preserving life, but allow death to occur with dignity and comfort, where death is deemed to be inevitable and where curative treatment appears to be futile".

The Australian Medical Association is not a body with a mind of its own. It presents the collective opinions of the members which in Victoria represent approximately seven out of every ten actively practising doctors.

The Association is not entrenched in its views on any matter, and is always willing to revisit policies and statements through the processes of internal debate, discussion and collective decision making.

In this regard the Victorian branch of the Australian Medical Association has undertaken to review its current policy on euthanasia.

We have all heard of surveys of the community regarding voluntary euthanasia. I must say that I do not believe that surveys have any place in determining the ethical or moral views of any society. These can only be obtained through exhaustive processes which involve detailed information, education, wide and deep discussion and debate before determining the consensus view.

Why do people want legislation for euthanasia? Why are people in our society looking for the protection of the law - is it for themselves, is it for the good of the whole of our society, is it for the good of a few people or is it for anybody's good?

It is my opinion that the laws are

made to protect society against people who wish to step outside the bounds of expected moral and ethical principles.

I do not believe that laws should be made specifically to cover minority situations - but situations where life decisions are made with experience, understanding, compassion and consultation that cannot be prescribed within legislation.

Any writing of the law leaves loopholes and provides opportunities that weren't meant to be there. One only has to look at the loopholes discovered in taxation laws in Australia to see the potential for this.

I agree with John D Buchanan who further wrote in the Age on 28 March 1995 that there were three inevitable consequences of legalising euthanasia.

They are:

- ◆ Firstly, that there would be pressure put on all terminally ill patients. This pressure would come from the perception of terminally ill patients that they are a burden to their family and everybody would be better off if they were dead.
- ◆ Secondly, it would create a change of the role of the health care professional to the detriment of society. The position of trust that health care professionals have in our society would be undermined.
- ◆ The third inevitable consequence would be that there would be pressure on all disabled people in society and he said "If the principle of a life not worthy to be lived is accepted, then a widening of the indications for homicide by consent would follow".

While the debate about euthanasia must be held within the full breadth of society, doctors are inextricably

woven into the boundaries of those discussions. Any law in this regard impinges on their feelings, their rights and the way in which they treat patients.

***Euthanasia would change
the role of the health care
professional to the detriment
of society***

Doctors are more familiar with ethical debate, having developed a framework of service delivery which has extremely high and well understood ethical values.

I am certain that many people have benefitted from the fact that the great majority of doctors have higher moral and ethical standards than those found in the average society.

Professor Norelle Lickiss has published that it is her conviction that a doctor must be the boundary bearing the pressure of society and individuals in the matter of euthanasia.

Doctors certainly bear the weight of their actions. Shelia Cassidy, a palliative care specialist from Plymouth General Hospital published in the Tablet of 25 March 1995:

"After I had watched the Dutch television film in which a man with motor-neurone disease was killed by his general practitioner, I felt so desperate that I cried. I sat shivering in my neighbour's armchair, begging him to light the fire because I felt so sick and cold".

She went on to ponder the plight of the doctor who had uttered that he would not sleep that night. She said perhaps he would be pacing his bedroom floor or trying to blot out the pain or explain to his wife and children, why he was not quite himself that night. Later she painted the picture in a hospital with the fear, prejudice, suspicion and rumour that would spread in relation to episodes of euthanasia

that happened within the walls of a caring institution which contained very much living fellow human beings, be they staff, relatives, or patients either being cured or terminally ill.

I believe that many of the calls to euthanasia are because of poor education and the lack of understanding of the availability of palliative care. While I am realistic to know that not every person can be palliated by currently available care, certainly, the great majority of people in our society are able to be.

I believe that our society needs to concentrate on educating health professionals about palliative care and to make certain that expert care is readily available to any person who requires it.

Before I close, I acknowledge that it is a very important issue that we are discussing but that there are many other more important issues for our society to address. Smoking maims thousands of Australians and kills 19 of them per day. If we spent as much time fighting smoking as we have considering and debating euthanasia in recent months, we would have prevented much more suffering than we are ever going to do through legalising euthanasia.

✦

Dr Peter Beaumont

(Talk given at the Launch of the Centre on 20 July 1995)

SHOULD EUTHANASIA BE LEGALISED ?

Many actions which the community believe to be immoral are also criminal, e.g. stealing, but not all, e.g. adultery. This article is about whether euthanasia should be legalised, not its moral status.

Case for legalising euthanasia

It is often said voluntary euthanasia should be legalised for the terminally ill under strict conditions. It is argued it is an abuse to use the criminal law to restrict citizens' freedom to follow their consciences to request consenting doctors to administer lethal drugs to them at the time of their choice. It is held euthanasia ought to be legalised if it is lawful to commit suicide. Opinion polls show a large majority of people support law reform to legalise euthanasia. Finally, it is claimed this change would not harm others nor limit the freedom of those opposed to euthanasia.

No moral right to legalise euthanasia

Respect for human life should be upheld in law because it derives from the nature and dignity of the human person who is essentially social. Human life is such a basic value for individuals and for society that the state has a duty to protect human life from intentional killing, albeit painless, without exception for the security of all. Law makers have no moral right to legalise voluntary euthanasia as though it would affect only the individuals concerned. It would give legal standing for one person to terminate the life of another upon request. The deliberate taking of a patient's life is a matter of public concern. It should not be made a lawful action.

Misleading comparisons

Law makers realise the withdrawal of burdensome or futile medical

treatment resulting in foreseen imminent death is not the same as performing an action to kill with deliberate intent. Allowing the natural dying process to take its course unimpeded is praiseworthy. The intentional killing of patients should be made criminal.

The legalising of euthanasia cannot be compared with decriminalising suicide. One who requests euthanasia to avoid pain may believe his or her life is not worth living. It is quite another matter to ask a doctor to act on this belief to terminate a patient's life. The prohibition of intentional killing of innocent persons is fundamental to the common good, the well-being of society and the law. It should not be negotiable.

Legalising euthanasia is not good for the community

There are serious social implications to legalising euthanasia. It would undermine the respect due to human life in the community as a whole. It would enable subtle and unspoken pressure to be exerted on the sick and elderly to choose death at the hand of doctors as a convenience for themselves, for others or for saving costs. The legalising of the right to choose to be painlessly killed generates an obligation for all the dying to choose one way or the other. Some will feel they are a burden to society and may feel a duty to request euthanasia.

Culture of life or death?

Our self-understanding is powerfully influenced by our culture, laws and institutions. Do we wish the social and legal acceptance of the institutionalising of terminating the lives of patients to fashion our culture, to shape our self-understanding and that of our young people, among whom an alarming rate of suicide already

exists? Surely we should opt for a culture of life, not death.

Doctors

It is unfair to doctors to legally authorise them to give lethal doses to their patients. They would be under pressure to comply. It would lower the standing of all doctors in the community. Their professional integrity and reputation as promoters of health and life would be compromised by a law licensing them to kill painlessly. The sick, elderly and terminally ill should have a lawful right to be attended

Duty to protect human life justifies limiting autonomy to forbid painless killing of patients

by doctors professionally committed to promoting health and life, not to painlessly killing their patients upon request. This sort of insecurity for the vast majority of people should not be sacrificed to satisfy a few who request euthanasia. Terminally ill patients visited by doctors in their homes or hospitals should not have to worry whether a doctor's white coat conceals a black lining.

Limits to autonomy

The community recognises the importance of personal autonomy and rightly only restricts it by law when this is required by policy for the common good, to protect the autonomy of others or to protect individuals from harm. All things considered, the rights of a few to follow their consciences to request euthanasia cannot extinguish the duty and right of law makers to uphold the sanctity of human life. Nobody should be swayed by arguments of misguided

compassion contrary to the common good. The duty to protect human life from direct lethal assault justifies limiting autonomy and freedom to forbid the deliberate taking of human life upon request.

Status quo is preferable to legalising euthanasia

It is claimed euthanasia is quietly practised in the community but the police are unable to take action because reports are not made to them. It is unlikely the participants or witnesses would report themselves! This situation may not be satisfactory, but it is no justification for legalising euthanasia.

Government reports

After a thorough analysis of the relevant evidence, the bipartisan Social Development Committee of the Victorian Parliament in its Final Report, **Inquiry into Options for Dying with Dignity**, in its first recommendation stated: "It is

neither desirable or practicable for any legislative action to be taken establishing a right to die." And I agree.

The 1994 **Report of the Select Committee on Medical Ethics of the House of Lords**, after examining the arguments, concluded: 'Ultimately, however, we do not believe that these arguments are sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and

widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.' (Paragraph 237)

✦

Dr Norman Ford SDB

Vale - ST VINCENT'S BIO-ETHICS CENTRE

St Vincent's Hospital took a conscious decision to establish a Bio-Ethics Centre in the early part of the last decade. The initiative for the establishment of the Bio-Ethics Centre came from Sister Maureen Walters, the Sister Administrator of St Vincent's Hospital at the time. She, in concert with Dr. Joseph Santamaria, Dr. John Billings, Dr. Eric Seal and Dr. Bernard Clarke, developed a policy for establishing a Bio-Ethics Centre, to address the various problems that pertained to difficulties in providing health care services for the whole community.

Nicholas Tonti-Filippini was the first Ethicist and then the first Director of the Bio-Ethics Centre.

A series of annual general seminars attracted wide interest and provided the community access to discussion of contentious issues in the matters of ethics in health care. Considerable input into publications by govern-

ment, legislation in the state government, contributions to the popular press in letters and special articles made the St Vincent's Bio-Ethics Centre conspicuous and identified the Centre as the major base of contribution of Catholic ethical opinion.

Education was offered, of course, to the community in various seminars, in visits to schools and to special meetings. Nicholas Tonti-Filippini was extraordinarily prominent in the focusing of Catholic principles and their emphasis in determining the rights and wrongs for looking after the health of the community. With the aid of a very competent and contributing committee, the Centre thrived.

About the time that St Vincent's Hospital took a new direction in its administration and management, it was determined that perhaps the St Vincent's Bio-Ethics Centre should give way to a centre more broadly

based across the Catholic hospital system and representing all the Catholic health communities.

The contributions of St Vincent's Bio-Ethics Centre can only be described as enormous and informative and, indeed, of major intellectual and educational input. The Director, the committee and the support from the Sisters of Charity and the Archbishop of Melbourne, all combined to provide a considerable influence.

The St Vincent's Bio-Ethics Centre, of course, would wish that the tradition that was established will extend in Australia through the work of the Caroline Chisholm Centre for Health Ethics. ✦

Dr Bernard Clarke

PURPOSES of the CENTRE

Drawing upon the ethical tradition and teaching of the Church and, as judged by the Centre to be appropriate, other Christian, religious and genuinely human perspectives, the purposes of the Centre shall be, in relation to ethics in healthcare, and without limitation:-

Policy and Program Development:

- ◆ to develop and contribute to the development of policy statements and protocols;
- ◆ to act as a source of advice to Healthcare Institutions, Healthcare providers generally, the Church and its agencies, and the wider community;
- ◆ to be an advocate in the development of policies by governments and their agencies, the Church and its agencies, and the wider community and to respond to proposals and reports from other bodies;

Educational and Public Awareness:

- ◆ to contribute to state, national and international debates and forums;

- ◆ to make public comment on major issues;
- ◆ to provide educational and training services, and information and consultancy services;

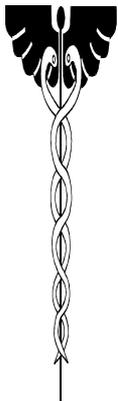
Research:

- ◆ to undertake research projects and provide research opportunities and encourage research;
- ◆ to publish and disseminate research findings and information arising from work of the Centre;
- ◆ to undertake commercial exploitation of any research undertaken and intellectual property rights owned by the Centre and to distribute any monies derived from its ownership as the Centre thinks fit in accordance with its purposes; and

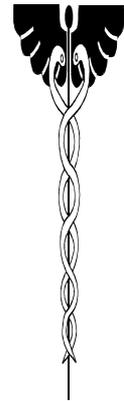
Links and Networks:

- ◆ to encourage and develop links with Catholic and other healthcare organisations, educational institutions, government bodies and wider the community.

*The Caroline Chisholm Centre for Health Ethics is sponsored by
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in Victoria:*



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The Centre's Bulletin is a quarterly publication

Subscription fees;
\$20.00 within Australia A\$25.00 Overseas

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MEMO FOR SECONDARY SCHOOL PRINCIPAL

Recently a complimentary copy of our Caroline Chisholm Centre for Health Ethics Bulletin was posted to your school. It is not written for academics and should be very useful for Religious Education teachers working through ethical issues in health care.

As we are preparing to produce our second issue of the Bulletin we need to know which schools wish to receive the next three issues for this financial year. Please return this subscription form NOW duly completed together with your cheque.

Overleaf is a list of health ethics resource materials with their respective prices, including handling fees.

Rev Dr Norman Ford SDB

Director

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