

Caroline Chisholm Centre for Health Ethics

BULLETIN

Vol 2 No 2

SUMMER

1996

From the Director

As mentioned in the last issue of the **Bulletin** our Centre held a conference on Treatment Decisions at the End of Life at St Vincent's Hospital on 15 November 1996. Thanks to the hard work of Margaret Casey and the Centre's research officers it was a great success with about one hundred registrations. It began with **Kevin Andrews** MP explaining the legal right to refuse medical treatment, but not palliative care or the reasonable provision of food and water. He emphasised that any intentional killing by any act or omission is illegal.

Dr **Bruce Tomlinson** presented the first of six clinical case scenarios by explaining the meanings of the *vegetative state* where there is no evidence for consciousness of self or the experience of pain. This condition is said to be permanent when it is diagnosed as irreversible with a high degree of clinical certainty. In all these cases medical and nursing care appropriate to each patient should be given. **Margaret O'Connor** discussed the ethical aspects of autonomy, treatment and quality of life in home hospice care. **Patty Hodder** raised the ethical problems encountered in treating the frail and aged in a nursing home, e.g. hydration and nutrition, invasive treatment, advocacy etc. **Dr Yeatman** discussed the same issues in a palliative care hospice. **Mary Archibald** discussed the ethical difficulties of treatment decisions in end stage renal care, such as quality of life, patient competency and resource allocation. **Christine Holland** raised the issues frequently faced in an acute care setting, e.g. when invasive treatment may result in likely death or survival with severe suffering and poor quality of life.

Professor **David Kissane**, speaking on the decision making process, stressed that individual clinical judgments should be guided by ethical principles with due regard to the proportionality of burdens and benefits. This would require treatment team meetings as well as family meetings.

I touched on the duty of reasonable care for health without any need to subject competent and incompetent dying patients to the burdens of every possible treatment. Particular attention was given to whether there is always a duty to provide artificial nutrition and hydration for those who were dying or in the permanent vegetative state.

Susan Lee highlighted the difficulty of seeking simple solutions for complex ethical issues. A framework of care was needed for the whole picture to give the context for moral

"Mt Alvernia A Franciscan Hospital, Bendigo"

principles and ethical decisions at the end of life.

The Conference Proceedings are being prepared for publication and will be available from the Centre in the New Year. They will be worth purchasing. The Conference Program is printed on the reverse side of the insert orderform in this **Bulletin**.



Norman Ford SDB

FEATURING

<i>Euthanasia: A Brief Examination</i>	2
<i>Refusal of Medical Treatment and Suicide: Victoria's Medical Treatment Act 1988</i>	4
<i>The Health System - Where is it Going?</i>	7
<i>Moral Respect Due to the Human Embryo</i>	10

Euthanasia: A Brief Examination

Some of the confusion about what is and is not euthanasia is discussed. The possible consequences of accepting euthanasia as part of medical practice are also highlighted.

What is Euthanasia?

A great deal of attention has been focused on euthanasia recently. It is a term used frequently but rarely with qualification or explanation. Before considering the current debate it is essential to remove any misunderstandings. Euthanasia is **not** about discontinuing futile treatment, rejecting burdensome procedures or administering pain relief which may as an unintended effect shorten the patient's life. Rather, **euthanasia is the intentional killing** of a person by either an act or omission in order to relieve suffering. Euthanasia resorts to someone, usually a doctor, removing the sufferer rather than addressing the causes of the suffering. One of the most frequent misconceptions involves the confusion of euthanasia with the refusal of burdensome, futile, exceptionally risky or costly treatment. If a patient con-

“A competent patient can refuse medical treatment”

siders that a treatment is no longer proportionate to any gains, or hope of improvement that it offers, then there is no moral obligation to continue treatment. A competent patient may refuse medical treatment and in the case of incompetent patients the same decision can be made, by either the person with enduring power of attorney (medical treatment) or, if one does not exist, the Guardianship Board. It is important to draw the distinction between cases of withdrawing treatment which are instances of euthanasia and those that are not. The distinction relies on the intention of both the competent patient and the doctor in discontinuing treatment. If treatment is withdrawn with the intention of causing death, it is a case of euthanasia. However, withdrawing because the benefits of treatment are disproportionate to its

drawbacks is not euthanasia.

When Withdrawing Treatment is Euthanasia

One way of determining whether a given situation should be considered an instance of euthanasia is to ask, ‘What would the doctor do if the patient continued to live?’. If a patient withdraws from a treatment because it is disproportionate to any expected benefit and remains alive, they will then receive the appropriate care. On the other hand if a patient withdraws from a treatment with the in-

“The intended outcome is to eliminate the burden”

tention of inducing their death and continues to live, the doctor would take further action to ensure the desired outcome, death, did occur. In the first example of withdrawing from burdensome treatment death is not the desired outcome. The intended outcome is to eliminate the burden for either the patient, the family or the community. In order to achieve this, treatment is ceased. If the patient does not die as a result of withdrawing from the treatment then no further action to hasten death is taken. In the second case, where death is the intended outcome, further action is required to achieve the desired result, the patient's death. This case is euthanasia. The patient has a suicidal intention of causing their death and the doctor withdraws treatment in order to achieve this. Withdrawing treatment because it is burdensome is not euthanasia.

Confusion Over End of Life Decisions

Further misunderstandings surround the moral difference between allowing patients to die of their condition and taking active steps to intention-

ally kill them. This confusion over what is and is not euthanasia, or more importantly the moral evaluation of the two cases in question, is evident in a recent Morgan Poll. The results of this Morgan Poll have recently been used to show that the majority of people support euthanasia but I think the results highlight the confusion surrounding the issue. The Morgan Poll conducted in September 1996 posed several questions about end of life medical decisions. Participants demonstrated two responses that appear to be conflicting. The first question asked concerns a “hopelessly ill” patient who is “experiencing unrelievable suffering”. There is “absolutely no chance of the patient recovering”. Participants were then asked should the doctor let the patient die or keep the patient alive as long as possible? Two thirds (66%) agreed the patient should be allowed to die. The second question asked if a patient who is hopelessly ill, experiencing unrelievable suffering, with no chance of recovering, requests a lethal dose, so as not to wake again, should the doctor be allowed to give a lethal dose

“It is morally repugnant to demand patients prolong their dying”

or not? To this question three quarters (76%) agreed that the doctor should be able to give a lethal dose. The interesting feature is that more people agree with doctors intentionally killing their patients than allowing patients to die of their condition. This result is unusual. One possible explanation is that people don't fully understand. Allowing a patient who is experiencing unrelievable suffering to cease life prolonging treatment seems reasonable. Actually, there is something morally repugnant in demanding that patients prolong their dying when they are in pain and

there is no hope of recovery. The fact that more people agree with doctors intentionally killing their patients, than simply allowing patients to die, demonstrates how confusing and misleading the whole question of euthanasia has become in the public domain.

Eliminating Reasons for Requesting Euthanasia

The example used in the Morgan Poll involves a patient with unrelievable suffering but with the advancements that have been made in palliative care it is rare now that patients experience such suffering. Unfortunately there are some who still do. For some of these euthanasia may appear to be a solution. Killing the sufferer, however, has to be considered a very poor solution and one we should attempt to avoid. It would be far more beneficial to concentrate on making further improvements to palliative care. If euthanasia was to be offered as an alternative to a pain management regime there would be little motivation or funds made available to look for more effective ways to control pain, especially for terminally ill patients. It is also important here to acknowledge, that in

“Killing the sufferer is a very poor solution”

the Netherlands, which is the only case study available for euthanasia, only 5% of patients listed pain as their most important reason for requesting euthanasia. Suffering featured on the list of most important reasons along with pointless suffering at 29% and 18% of patients listing unbearable suffering as their most important reason. Although these are some of the areas palliative care focuses on, one other reason, fear of humiliation, was rated by 24% as the most important. This is something that in the right environment and with support patients should not have to be concerned about. The reasons patients give for requesting euthanasia should assist in directing care and focussing attention on their needs so death is no

longer seen as a solution.

Consequences of Accepting Euthanasia

Frequently discussed with respect to euthanasia are ‘slippery slope’ or ‘the thin edge of the wedge’ arguments. These kinds of arguments are used to demonstrate the likely results of accepting any type of euthanasia as morally permissible. Although it is not necessary to agree with any form of euthanasia in order to be persuaded by ‘slippery slope’ arguments they can be useful in assessing the consequences of accepting any kind of euthanasia. The arguments follow the general form that **even if** one accepts that active voluntary euthanasia is in some situations morally permissible, its acceptance as a practice will lead down an inescapable slope to accepting involuntary euthanasia. History has shown that such arguments should carry some weight. Whatever limits are placed on a practice upon its introduction, regardless of how strict they are, will disintegrate to such an extent that they may be relaxed completely. Abortion is an obvious example. The decision to permit abortion in some strictly defined cases, has led without further intentional liberalisation to the equivalent of abortion on demand. Once the door is open the journey down the slope is unavoidable. Some of those in favour of euthanasia deny that a ‘slippery slope’ exists and would have us believe that in practice we can effectively limit euthanasia to just voluntary euthanasia. The Dutch thought they could do this too. Now in the Netherlands both involuntary and non-voluntary euthanasia occur frequently. Realistically, once the unthinkable, in this instance euthanasia, is tolerated in a society it needs only time before it becomes common practice. Once voluntary euthanasia is an accepted component of medical practice there will be cases where consent is presumed or simply considered unnecessary. It is the consequences suggested by these type of arguments which should concern everyone.

Voluntary euthanasia is one thing but killing those who have not requested death is another. Killing innocent people without even their request or consent is a consequence of accepting voluntary euthanasia and one that cannot be avoided.

Sick and Elderly Would be Most Affected

Accepting euthanasia would see the sick and elderly suffer the most. Those who are in some way a burden on their carers or society would be forced to question their continued existence. If euthanasia is part of medical practice the sick and elderly, especially those whose care is particularly costly to the community, will be required to justify why they are not taking up the option of a swift and painless death. It would be deplorable if society demanded people justify their fight against disease or age. Dying is often a process that occurs over time and provides people with time to prepare for death and to finalise any outstanding matters they may have. To be forced to question whether or not one is justified in taking that time or why one is not quite ready to die, is appalling.

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Tracey Scott

Please note!

The Centre will be closed over the Christmas period from close of business 24th. December, 1996 to Monday 13th. January, 1997

Refusal of Medical Treatment and Suicide: Victoria's *Medical Treatment Act 1988*

*In the light of current discussions about Euthanasia and the Northern Territory's new laws I will look at the right to refuse medical treatment under Victoria's **Medical Treatment Act (1988)**, including the right of agents, under an Enduring Power of Attorney, to refuse medical treatment for incompetent patients.*

Introduction

In England, long before laws became enshrined in acts produced by parliaments, it was recognised that people had certain rights and responsibilities, both to themselves, others and society. This law is known as the *common law*, developed by judges and the court system over hundreds of years. When the English settled Australia they brought their legal system with them. Consequently, much of Australian law is still based on the common law, although of course this law is now supplemented by numerous acts of parliament.

There has always been a common law right in Australia to refuse unwanted medical treatment, even if that treatment would save the life of the refusing person. Based on the law of trespass, it is a recognition of the right of an adult person, with full mental capacity, to be free of uninvited physical contact irrespective of what others, including doctors, may think is in the best interests of that person. Nonetheless, two states and the two territories considered that the protection afforded to the patient's right to refuse treatment under common law in Australia was inadequate and have enacted legislation which clarifies this right. In 1983 South Australia enacted the *Natural Death Act*, recently repealed and replaced by the *Consent to Medical Treatment and Palliative Care Act 1995*. In 1988 the Northern Territory enacted the *Natural Death Act* and then in 1995 the *Rights of the Terminally Ill Act*. In 1994 the ACT enacted the *Medical Treatment Act*, while Victoria has enacted the *Medical Treatment Act 1988* and the *Medical Treatment (Enduring Power of Attorney) Act*

1990. All other states are still covered by the common law.

In addition to the right to refuse medical treatment, the law against suicide has been abrogated. It is no longer a criminal offence to attempt suicide, with the law recognising the autonomous right of individuals to choose their own destiny. However, in all states (other than the Northern Territory where new specific provisions apply under the *Rights of the Terminally Ill Act*) it remains a serious criminal offence, encoded in legislation, to counsel, procure or aid another to kill himself or herself.

In this article I will examine the legal provisions of Victoria's *Medical Treatment Act 1988* ("MTA") and *Medical Treatment (Enduring Power of Attorney) Act 1990* ("EPA"). In later articles I will examine and compare the provisions of refusal of treatment and right to die legislation in other states, in the light of the recent developments on euthanasia and assisted suicide in the Northern Territory.

The Right to Refuse Treatment

In Victoria the MTA was enacted, according to the preamble to the Act, because Parliament recognised that it was desirable to give protection to the patient's right to refuse unwanted medical treatment and to give protection to medical practitioners who acted in good faith in accordance with a patient's express wishes. The main reason envisaged for the refusal of treatment was to enable terminally-ill patients to refuse pointless and burdensome medical therapies that would be unable to cure the illness from which they suf-

fered, but would simply prolong their dying process. In the words of the preamble, parliament recognised that it was desirable:

...to encourage community and professional understanding of the changing focus of treatment from cure to pain relief for terminally-ill patients [and] to ensure that dying patients receive maximum relief from pain and suffering.

The MTA becomes operative upon the creation of a valid "refusal of treatment" certificate, the form of which is outlined in Schedule 1 of the MTA. The certificate is to be signed by two witnesses - a medical practitioner and another person (s.5 (1) and s.5(2)). There is provision for the patient refusing the treatment to sign the certificate also, but in the event that the patient is physically unable to do so, it is not necessary.

"Clarifies and reinforces the right of patients"

The MTA clarifies and reinforces the right of patients to refuse medical treatment by providing a procedure whereby a patient can register a refusal to accept medical treatment. The MTA works in two ways. First, if the medical practitioner knowingly gives treatment in breach of the certificate he or she will be guilty of the offence of medical trespass. S. 6 states that:

A medical practitioner must not, knowing that a refusal of treatment certificate applies to a person, undertake or continue to undertake any medical treatment which the person has refused, being treatment for the

condition in relation to which the certificate was given.

Secondly, if the medical practitioner acts in good faith in reliance on the certificate, he or she is protected from professional, civil and criminal liability. S.9 of the *MTA* states that:

A medical practitioner...who, in good faith and in reliance on a refusal of treatment certificate, refuses to perform or continue the medical treatment which the person has refused is not... guilty of misconduct...guilty of an offence or liable in any civil proceedings because of the failure to perform or continue that treatment.

Informed Consent and a Current Condition

There are however, specific qualifications both on the ability of a patient to sign a refusal of treatment certificate, and on the medical practitioner being allowed to rely on the certificate. According to s.5(1)(c) both the medical practitioner and the other witness to the certificate must be satisfied that the patient has been fully informed about the nature of his or her condition and has fully understood the information. In addition, s.5(1)(a) outlines that the treatment being refused must only be for a "current condition". If for example a patient is suffering from terminal cancer and signs a refusal of treatment certificate with regard to treatment for that cancer, they are not also allowed to rely on the same certificate in order to refuse treatment for, say, diabetes.

Palliative Care

The *MTA* is very specific about the fact that while patients may refuse "medical treatment", this treatment does not apply to "palliative care"; a patient is not allowed to refuse the provision of palliative care (s.4(1)), defined in the act as "reasonable medical procedures for the relief of pain, suffering and discomfort" and

"reasonable provision of food and water" (s.3).

This last phrase could be quite problematic. Often, in the final stages of a terminal illness, a patient finds that taking food and water is burdensome, in much the same way that many ill people find that they do not feel like eating. If a dying patient is not allowed to refuse the "reasonable provision of food and water" does this mean that they should be force-fed against their will, causing them discomfort and prolonging their dying in the process? Although there has been no court case to decide the correct interpretation of this particular section, the answer would lie in the way that the word "reasonable" is interpreted. If giving a patient food and water, either artificially or via a tube, is going to cause them severe discomfort then it could surely not be considered "reasonable" to force them to take it.

In addition, the *MTA* specifically says in s.4 that "this act does not affect any right of a person under any other law to refuse medical treatment". It is possible that while a patient may not be allowed to avail themselves of a refusal of treatment certificate because the provision of food and water is considered to be palliative care, they may be entitled to refuse it under the *common law* right to refuse medical treatment.

Suicide or the Right to Die?

One of the arguments that was put forward by opponents to the *MTA* when it was first being debated in parliament was that it would enable patients to commit suicide. However, this turns on the interpretation of the word suicide, and on the intention of the patient. S.463B of the *Crimes Act 1958 (Vic)* states that someone may use "reasonable force" to prevent the commission of suicide. This section of the *Crimes Act* is still in force because s. 4(3) of the *MTA* specifically makes it clear that

it is preserved in this context. Some patients may have suicidal intentions quite unrelated to their medical condition. In such cases the use of force to prevent the suicide might be justified: the principle underlying *MTA* and s.463B of the *Crimes Act* could justify a doctor's refusal to witness a refusal of treatment certificate or giving treatment in contravention of such a certificate, if the doctor truly believed that the patient was refusing treatment solely in order to commit suicide.

"Not showing contempt for life"

However, the intention of the *MTA* is to allow patients to freely make decisions about their own treatment. In the more typical case a patient will not be seeking to die. In most cases they will probably already be dying. What is sought is not death, but freedom from the treatment which is prolonging life on unacceptable terms. In addition it is a better allocation of scarce resources. A terminally ill patient who prefers an early, painless death to the painful prolongation of life is not showing contempt for life but simply exercising their right to refuse useless and burdensome treatment. The law grants the patient the right to do this and does not consider such refusal to be suicide. Nor will the law regard that a doctor, who has withdrawn treatment in accordance with the patient's wishes, be assisting the patient to commit suicide. However, the law in Victoria forbids the patient the right to compel medical personnel to assist in any way in the *furtherance* of the refusing person's wish to die.

The Right of Agents to Refuse Medical Treatment

Under the *MTA* there is no provision for 'living wills': that is, someone cannot give advance directives as to refusal of medical treatment in the event that they become incompetent at some stage in the future. Instead, the *MTA* allows for a competent per-

son to appoint an agent with an enduring power of attorney ("EPA"). In the event that the person becomes incompetent, the agent with the EPA is entitled to make decisions as to medical treatment on behalf of the incompetent patient. Unless a person has been appointed as an agent by the patient, there is no power to refuse treatment on behalf of that patient. However, if relatives of an incompetent patient have a dispute about medical treatment with either medical personnel or with each other, they may apply for guardianship to the Guardianship and Administration Board. Such guardians are granted the same powers to refuse medical treatment on behalf of the patient as agents who were appointed under an EPA.

An agent or guardian may request a refusal of treatment certificate for a current condition of the patient, and a medical practitioner and another person may issue a certificate if satisfied that the request is freely and informedly made (S.5B(1)). Treatment may only be refused if:

...the treatment would cause unreasonable distress to the patient, or, there are reasonable grounds for believing that the patient, if competent, and after giving serious consideration to his or her health and well-being, would consider that the medical treatment is unwarranted.

"Not by its nature distressing but would cause distress to a particular patient"

It is possible that medical treatment that causes "unreasonable distress" could also be construed to include treatment that is not by its nature distressing but would cause distress to a particular patient: for example, giving a blood transfusion to a Jehovah's Witness to whom a blood transfusion would be against their religion. Other than these sort of considerations however, it would appear that this is an objective criterion so that medical opinion as to what

would be distressing to the patient will be of some importance. The second part of the restriction appears to be more concerned with what the patient would have considered warranted, regardless of medical opinion. Therefore, the agent or guardian would need to be fairly clear as to what the patient would have wanted under the circumstances.

The insertion of this restriction on the power of the agent was a response to the suggestion that agents would be able to refuse any treatment on behalf of the patient, even where the treatment proposed was appropriate and proportionate. In addition, to further restrict the agent's power, if a doctor is particularly concerned about the refusal of treatment by an agent or guardian, he or she can apply to the Guardianship and Administration Board to have the EPA suspended or revoked (s.5C). In this situation, decisions as to medical treatment can then be made by the Board. This power acts as a safeguard in the event that an EPA may be abused by the agent.

Conclusion

The rationale of the Medical Treatment Act and the Medical Treatment (Enduring Power of Attorney) Act is to ensure that patients are not burdened with futile treatment. In addition, doctors should not be fearful that if they withdraw futile treatment at the request of the patient or agent, that they will be liable to prosecution. However, it is important to recognise that Victorian law does not allow or require that doctors deliberately end patients' lives, even at the request of the patient. The law recognises a distinction between allowing a terminally ill patient to die and actually helping them to die.

Sources

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Anna Stokes

PROCEEDINGS OF THE CONFERENCE

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The Health System - Where is it Going?

This article will discuss the role of the general practitioner, the divisions of general practice and the proposed changes to the Australian health system.

The primary purpose of any health care system is the improvement of health outcomes by reducing mortality and morbidity, improving quality of life and objectively extending the average life expectancy (without having to live with burdensome chronic disease). The system needs to include primary prevention (education), early diagnosis, efficient and accepted disease management of both the initial illness and any subsequent complications, and end stage terminal care. Given these criteria the Australian health care system for the most part works well, and by world standards (health status) is reasonably efficient. Access to many health services, especially emergency medical help, is fairly equitable but the system's major weakness is that its focus in the past has been on providers and programmes rather than on people and outcomes. An outcome in a health context can have several components - survival, which is necessary but not all sufficient; well-being; an intermediate measure such as 'so called' normalisation of blood pressure or blood glucose in the case of hypertension or diabetes; or quality of life which is hard to assess but an essential measure.

"From a push model of health to a pull model"

Recognition of the system's past focus (as well as the knowledge that in the future there will be increased demand for services) has compelled the Australian government and its departments to reassess the various methods of delivering health care to the public. The overall objective seems to be a change from a push model of health to a pull model whereby it is hoped that the person requiring the health care services will be able to choose and then access them accordingly.

A large component of the cost of pa-

tient care in Australia is the consumption of secondary and tertiary health resources such as referred specialist treatment and acute care hospital services. In the last few years there have been many attempts (particularly in Victoria) to reduce the length of hospital stay by early discharge, and to decrease the need for hospital admission by switching the emphasis from secondary or institutionalised care to primary care out in the community. This community care focuses on the general practitioner and other community services.

"Keep people in their own homes"

Improved technology, changes in surgical procedures which require less acute recuperation (such as key-hole surgery), different treatment plans, and an increase in the number of day surgery operations have contributed to the move away from long stay acute hospital admission. In order that people recover adequately following an illness a number of changes to the organisation of health care services and facilities has been formulated, some of which have already been initiated. High quality community-based support is essential in order that there be continuity of care after hospitalisation. 'Hospital in the home' is an example of community based care where patients are treated at home by visiting service providers with such therapies as intravenous antibiotics and feeding. This will apparently broaden to accommodate other services for the chronically ill, such as chemotherapy, dialysis, and pre and post-operative tests and care in the future. Shared care and the divisions of general practice are other examples of relatively new strategies that have been developed to either keep people in their own homes rather than having to be hospitalised, or as ways

to enable early discharge following a hospital admission.

The Role of the General Practitioner

One of the ways to ensure an optimal standard of care in the community is to enlist the support and expertise of the general practitioner. The general practitioner has always occupied a central position in the provision of primary care in Australia. It seems that we have followed the English in that specialist care requires an appropriate referral from the general practitioner who acts as the gatekeeper to specialist services. In America there has always been self referral where the patient decides which specialists they 'need' to visit. While on the one hand this may seem to give the patient autonomy and the right to consult whom they please, it also contributes to increased health care costs as uneducated, unaware patients may see several specialists before they visit the relevant one. As Sir Douglas Black stated in the *Journal of Medical Ethics* general practitioners are "in a position to modify public expectations of what medicine can (or cannot) do; and to control access to expensive, and it may be unnecessary diagnostic and therapeutic procedures in the hospital sector."

"One of the biggest strengths of general practice lies in the doctor/patient relationship"

As medicine becomes more specialised and complex the general practitioner's role as the integrator or coordinator of the health services for patients has become increasingly important but difficult. Geoff Mitchell says the following about general practice - "What makes general practice different from a specialty is the breadth of the experience required, and the ability to place a disease in the context of a person who

is influenced by environment, family, job, beliefs, finances and intelligence." One of the biggest strengths of general practice lies in the doctor/patient relationship - a relationship that stands to be eroded if the bulk billing 24 hour/day medical clinics become too popular. General practitioners in Australia have to facilitate the patient's access to the whole health care system. They can interpret the system to the patient, explain the nature of the illness, the implications of the treatment, and its effect on the patient's way of life as well as making referrals to other services to which the patient may require access. The general practitioner may also help the patient to make decisions about their treatment.

The Divisions of General Practice

Given the seemingly positive role of the Australian general practitioner and the universality of the public's access to them via Medicare, there has been a move in the last few years to increase their profile and enhance their relationship with each other and with acute hospital services. This strategy has come under the guise of the Divisions of General Practice. These divisions organise general practitioners (participation is voluntary on the part of the general practitioner) from a geographically determined area into a structure. This structure is recognised by the local hospitals and health care services. Such a relationship will improve communication and involvement of general practitioners in the local health services and facilitate cooperation between general practitioners. The divisions themselves set their own local priorities but the overall aim is to improve the health care of their patients.

"Lack of consultation between general practitioners and hospitals"

There are many reasons why the Divisions of General Practice were seen as a necessary addition to the health system structure and the fol-

lowing are but a few. In the past individual general practitioners have been excluded from the care of their patients when admitted to hospital and there was a lack of consultation between general practitioners and hospitals. Now many divisions have negotiated 'shared care' for their patients when admitted to a local hospital. Affiliation with local hospitals means that general practitioners are notified when their patients are admitted; there is an exchange of information between the general practitioner and hospital staff; the general practitioner can visit the patient in hospital and then be involved in the patient's discharge planning.

Probably one of the most important reasons which necessitated the growth of the divisions has been the changing patterns of illness from acute to chronic which has meant that patients require on-going medical care, not just acute hospital admission. It is the general practitioner who is perhaps best placed to coordinate this care or at least to provide

"Increased consumer awareness"

the continuity of medical treatment. It was also felt that there was a fragmentation of patient care and lowering of standards of general practice especially as many general practitioners worked in isolation or in small practices and had very little time or opportunity for ongoing education or research. Now with defined local networks of general practitioners who are commonly linked together a continuing, accredited medical education programme can be provided. Another incentive for upgrading general practitioner education is increased consumer awareness which means that the public expects general practitioners to be more informed. General practitioners are also able to develop projects for submission for funding from the Commonwealth Department of Health & Family Services and other appropriate health agencies with the assistance of the divisions' infrastructure.

So far the Divisions of General Prac-

tice seem to be a very forward looking development that in the long run will have a positive effect on the health status of patients. By improving communication, liaison and cooperation between general practitioners themselves and between general practitioners and local health care services and hospitals, it is hoped that there will be a more planned approach to a patient's health care rather than ad hoc decisions which are made without reference to the consequences for the patient themselves or for those who will be coordinating their care in the home environment. The divisions must be careful that they don't accept too much responsibility for the coordinating and administering of treatment and care of their patients without appropriate budget guarantees. Increasing budget pressures in other areas of the health care system have meant searching for another way in which to provide equivalent care more efficiently. This other way may just involve the general practitioners. The pressures from casemix and early hospital discharge may need the divisions of general practice to facilitate the transfer of increased treatment and care responsibilities to community general practitioners.

Changes to the health system structure

Changes to the health system are really long overdue when one looks at the structure of Australia's current funding arrangements - some services are capped, some are uncapped, some are salaried, some are fee-for-service, some are exclusively for in-patients, and some are exclusively for ambulatory care. The Australian governments via COAG (Council of Australian Governments) are going to try to reform the health care system as a whole, with three streams of care rather than with ad hoc changes which have been the way of the past. The underlying plan seems to be the replacement of the 60 government funded programs with the simplified structure of only using three streams.

Three Streams of Care

The current proposal is to coordinate services by dividing consumer need into these three categories. Firstly there are those people who have only occasional and uncomplicated needs. These people come into the category of *General Care* which will cover the walk-in walk-out services. This will also cover health promotion and preventive health and community measures. The general practitioner has an important role in managing this sort of care as it is essentially community oriented and it seems that in fact it will require building on the role of the emerging Divisions of General Practice. The second category of *Acute Care* will cover those people who have one-off needs of an acute episodic nature. The episode of care need not be in a particular or single institution and after the episode of treatment the pa-

“Support people at home with the relevant services”

tient can return to self management or to another care category. The third category of care which has caused the most media profile and academic interest is that of *Coordinated Care*. People in this category require a comprehensive mix of services over a period of time to meet their needs. These services are often difficult to self manage, especially if you are chronically ill or disabled. Part of the agenda in integrating this sort of care is to support people at home with the relevant services for as long as possible. Apart from the frail aged, the disabled and people with long term mental problems there are people with chronic medical conditions whose ‘needs’ are best met by general care services but who would benefit from having this care centrally coordinated. The package of services that would be provided would include primary health and community services, pharmaceuticals, intensive health and community services and residential care.

The priority according to the government is to improve clinical outcomes by better service delivery and effi-

cient resourcing with a planned and integrated approach to patient care. These outcomes will be measured by looking at whether - hospitalisations are prevented or reduced, functional status is improved, assessment and diagnosis are made more efficient and accurate, survival is prolonged, medication intake is reduced and there is better matching of patient needs for services. Coordinated care will be assessed as successful if the outcomes achieved are better than if the patient repeatedly used acute or general care which involve episodes of care rather than a coordinated plan. A designated coordinator will

“Working definitions of ‘quality of life’”

take responsibility for organising individual patients’ plan in consultation with the patients themselves. In principle the concept of coordinated care would seem to have the potential of being of benefit to those people with ongoing complicated health care needs. It is going to be trialed and assessed comprehensively before any commitment to such a radical change to the delivery of health care in Australia is made. There have been several criticisms already. It has been argued that if adequate satisfaction of health care needs is to be achieved there will be a massive blow out of the health care budget. In reality it may be a cur-tailing of health service delivery rather than an expansion, if part of the agenda is to restrain costs. In fact coordinated care has been equated with ‘managed care’ in America and ‘general practitioner fundholding’ in England where there has been much criticism of these mechanisms in their capacity to firstly, control and restrict the delivery of health care services and secondly in the power and autonomy they give to health organisations (in America) and general practitioners (in England). Chronic illness consumer groups have concerns about working definitions of ‘quality of life’ as they feel health status can be related to more than just access to those mainly medically related and

community services which will come under the umbrella of coordinated care. “Members of the Chronic Illness Alliance identify quality of life, not in terms of access to the health system but in terms of access to all the things that well people aspire to, such as employment and income and family life and a future for their children”.

The Australian health care system is and will be undergoing changes to its structure and to the way in which services are delivered in order to improve health outcomes and limit costs. If we don’t recognise that we cannot possibly fund what is and will be, technologically possible to do, these changes are inevitable.

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Deirdre Fetherstonhaugh

Moral Respect Due To The Human Embryo

Human embryos are subjected to destructive research or are discarded in some reproductive centres in Australia. This article discusses the moral issues underlying human embryo experimentation.

Destructive Embryo Research

Fertility drugs are used to induce infertile women to ovulate up to ten or more eggs. Following superovulation the eggs are harvested and fertilised. Only a few embryos are normally implanted in a woman's womb during any one cycle and so the remaining embryos are cryopreserved (frozen) for implantation at a later date. Unfortunately up to a third or more of human embryos do not survive the freeze-thaw process. Often spare embryos are made available for destructive research.

“Embryos are allowed to succumb or are used for research”

Embryo biopsy is a procedure whereby one or two cells are excised from an eight-cell embryo to test them for serious genetic diseases. It can also be used to determine the sex of an embryo in suspected cases of sex-linked diseases like haemophilia or Duchenne's muscular dystrophy. If the biopsied cells are affected by the disease the embryos from which they were obtained will likewise be affected. Healthy embryos would be transplanted to the womb, but genetically defective embryos would not be implanted in order to prevent the birth of children with genetic diseases. They would be allowed to succumb or be used for research. Destructive research on embryos could help improve infertility treatment procedures or the production of more effective contraceptive pills.

Why is Embryo Research Thought to be Ethically Permissible?

While most people agree some respect ought to be shown to the human embryo, philosophers like Professor

Peter Singer and Baroness Warnock and many legislatures in the world do not think absolute respect is due to them. They accept human embryos and fetuses are members of the species *Homo sapiens* but they deny they are persons. Because they do not believe in a spiritual or immaterial soul to account for a rational nature they do not attribute personhood to human individuals before they show minimal signs of being rational and self-conscious beings who have interests, desires and a sense of the future. For serious reasons they hold that destructive embryo research could be done on human embryos and likewise abortion would be morally permissible provided the fetus did not experience any pain. While the reasons for these experiments are laudable, is it morally right to deliberately destroy human embryos in this way?

Definition of a Person

The classic definition of person was given by Boethius (d. 526) and expressed by St. Thomas Aquinas as follows: "The term 'person' signifies something complete, subsisting in its own right, in a rational nature." A human individual is an ongoing entity that is one, notwithstanding the multiplicity of its parts and organs, who exists in itself and not merely as a part of a greater whole. Rational acts and experiences do not

“A living individual with a truly human nature is a person”

exist in themselves: they are expressions of the human individual who is their subject. This does not mean that personhood should be restricted only to those who already have acquired the ability to exercise acts of rational self-consciousness and free choice. The human embryo, fetus, and infant are persons because of their inherent

natural active capacity to acquire the ability to exercise rationally self-conscious acts while remaining the same developing human individuals. They gradually realise their natural potency to express more fully what they already are. Human personhood exists wherever there is a living individual with a truly human nature. In this view the spiritual soul accounts for the human individual's rational nature and personhood from its inception. It is confusing for the community to talk of a human person as something distinct from 'a human being' or 'a human individual'.

Does a Person Need a Functioning Brain?

A functioning brain is a pre-requisite for the exercise of rationally self-conscious and free acts. The brain is not conscious, but the human individual is conscious thanks to a functioning brain. The individual with a human nature is the subject of existence, rational self-conscious acts and all the functioning brain's activities. Consequently it is not necessary to require that the brain be formed before a person could be present. Once living matter forms an ongoing individual and begins to actualise its natural potential for human adulthood in a continuous developmental process without loss of identity, that individual already has a human nature and is a human person.

A Human Person from Conception

The fusion of the male and female gametes results in the formation of a new cell, the zygote whose unique genetic identity or genotype remains practically unchanged during normal development. It is generally accepted that normal unidirectional and continuous biological development and growth would be sufficient to estab-

lish the zygote as the one and same living being as the future human adult who derives from it. It is human nature that enables embryos to develop to the stage where, without ceasing to be substantially the same living beings, they can exercise rationally self-conscious and free acts. Hence the zygote is regarded as an actual human individual and not simply a potential human person in much the same way as an infant is an actual human person with potential to develop to maturity. The Catholic Church accepts the zygote arising from the fusion of the two gametes is a person and is the beginning of the *development of the human being*. While the Church's *magisterium*, as we shall see, does not formally teach the zygote is a person, the Church rightly teaches the human embryo should be treated as a person from conception.

Some scientists and philosophers, including myself, do not see how the human embryo could be a person before individuation occurs with the appearance of the embryo's cranio-caudal axis about fourteen days after fertilisation. They all find it difficult to accept there is sufficient evidence to prove the zygote already is the one and the same individual and person as the adult who derives from it. The first 14 days seems to be the beginning of the *synthesis of a human individual*.

Biblical, Christian and Human Duty to Respect Human Embryos

The whole of the Bible shows that human life and its formation are exclusively in the hands of God, the creator. From early Christian times human life has been regarded as sacred and morally inviolable from conception.

The early Christians instinctively recoiled from the pagan practices of abortion and the allowing of unwanted newborn infants to die of exposure. The christian tradition always held that the deliberate destruction of nascent human life was a serious violation of the moral law. The

most authoritative statement of this tradition was made by the Second Vatican Council, even though the drafting commission had no intention of touching on when the soul was created to constitute one as a person: "Life once conceived must be protected with the utmost care; abortion and infanticide are abominable crimes".

Human life is to be respected from conception simply because it is human life, irrespective of when the human person begins. This theological and philosophical insight for protecting human life from conception encapsulates a profoundly human perception of the value of human life.

Catholic Teaching on the Moral Status of the Human Embryo

Pope John Paul II in his Encyclical Letter *Evangelium Vitae* discussed the moral obligation of protecting human embryos in the context of condemning abortion: "Procured abortion is the deliberate and direct killing, by whatever means it is carried out, of a human being in the initial phase of his or her existence, extending from conception to birth." (n. 58)

He then presented Catholic teaching on the moral respect due to human embryos from conception: "Some people try to justify abortion claiming that the result of conception, at least up to a certain number of days, cannot be considered a personal human life. But in fact 'once the ovum is fertilised, a life is begun which is neither that of the father nor of the mother; it is rather the life of a new human living being (*novi viventis humani*) who grows of its own accord. It would never be made human if it were not human already. Modern genetic science very plainly confirms these things, which were always quite clear ... It has demonstrated that from the first instant there is established the structure or program of this living being: namely a man (*hominem*), and indeed this individual man (*hunc hominem individuum*), with his own proper operations already determined

in advance. Right from fertilisation the wonderful course of a human life begins, whose powerful individual capacities require time to be correctly arranged and prepared to act'.

"A person is already present from the first appearance of human life"

"Even if the spiritual soul cannot be shown to be present by any empirical evidence, the very results of scientific research on the human embryo provide 'valuable indications, from which by the use of reason, it is possible to discern that a person is already present from this first appearance of human life: how could a living human creature (*vivens creatura humana*) not also be a human person'?"

"Furthermore, what is at stake is so important that, bearing in mind moral duties, the mere probability of the presence of a person would clearly forbid any actions aimed at killing a human embryo. Precisely for this reason, over and above all the discussions of the learned and the affirmations of philosophers, to which the Magisterium has never clearly been a party, the Church has always taught and continues to teach that to the fruit of human generation, from the first moment of its existence, there must be given the unconditional respect that is morally due to the human being in all its totality and unity, both corporeal and spiritual. 'A human creature is to be respected and treated as a person from conception; and therefore from that same moment his rights as a person must be recognised, among which in the first place is the inviolable right of every innocent human creature to life.'" (n. 60, my translation of the official Latin text).

Experimentation

"Although one must hold as licit procedures carried out on the human embryo which respect the life and integrity of the embryo and do not involve disproportionate risks for it, but rather are directed to its healing, the

improvement of its condition of health, or its individual survival, it must nonetheless be stated that the use of human embryos or fetuses as an object of experimentation constitutes a crime against their dignity as human beings who have a right to the same respect owed to a child once born, just as to every person". (n. 63)

Role of the Law

"While public authority can sometimes choose not to put a stop to something which -- were it prohibited -- would cause more serious harm, it can never presume to legitimise as a right of individuals -- even if they are a majority of the members of society -- an offence against other persons caused by the disregard of so fundamental a right as the right to life. The legal toleration of abortion or of euthanasia can in no way claim to be based on respect for the conscience of others, precisely because society has the right and the duty to protect itself against the abuses which can occur in the name of conscience and under the pretext of freedom." (n. 71)

"Laws which authorise and promote abortion and euthanasia are therefore

radically opposed not only to the good of the individual but also to the common good; as such they are completely lacking in authentic juridical validity. Disregard for the right to life, precisely because it leads to the killing of the person whom society exists to serve, is what most directly conflicts with the possibility of achieving the common good. Consequently, a civil law authorising abortion or euthanasia ceases by that very fact to be a true, morally binding civil law." (n. 72)

"A human person is to be respected and treated as a person from conception"

Certainly allowing destructive research on embryos while real doubts persist concerning their individual and personal status would be morally, socially and politically irresponsible.

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The Centre's Bulletin is a quarterly publication.
Subscription fees; \$20.00 US\$25.00 Overseas

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