Caroline Chisholm Centre for Health Ethics

BULLETIN

Vol 2 No 3 AUTUMN 1997

From the Director

Some ambiguity has arisen in recent weeks concerning the incidence of the practice of euthanasia in Australia following the publication of "End-of-life decisions in Australian medical practice" by Dr Helga Kuhse *et al.* in the Australian Medical Journal. In *Evangelium Vitae* n.65 Pope John Paul II defined euthanasia in agreement with the Christian moral tradition, and gave some guidelines for making decisions to refuse unwarranted medical treatment:

"Euthanasia, in the strict sense, is understood to be an action or omission which of itself and by intention causes death, with the purpose of eliminating all suffering. ...

"Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment,' in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted.' Certainly there is a moral obligation to care for oneself and to allow oneself to be cared for, but this duty must take account of concrete circumstances. It needs to be determined whether the means of treatment available are objectively proportionate to the prospects for improvement. To forgo extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death."

It is important to understand the difference between the *direct willing* of an action or omission with its intended effect and the *permitting of a foreseen* side-effect of one's chosen action or omission for a proportionate reason. One who foresees that the natural dying process will proceed as a result of withdrawing futile or burdensome medical treatment acts ethically. The intention would normally be to prevent prolonging the dying process. The justified withdrawal of futile life saving medical treatment is not euthanasia but simply good medical practice. Doctors in such cases should not believe they are performing euthanasia.

A flaw in the definition of euthanasia in the Church's 1980 *Declaration on Euthanasia* and quoted by Dr Kuhse, may have caused some confusion, even though it said disproportionate means of treatment were not morally necessary: "By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated." The Pope changed the **or** to an **and** to make the intention to cause death essential for the moral definition of euthanasia. ✣

Norman Ford SDB

"Cabrini Hospital — compassionate, competent care for all those we serve"

FEATURING

Protecting our Children!

This first of two articles will discuss the facts of immunisation -- the schedule, rates of vaccination and the consequences. The terms 'vaccination' and 'immunisation' will be used interchangeably, which is the case in most documents, although their exact definitions differ, as will be shown.

What is Immunisation?

Immunisation refers to the process of being given a vaccine (specific to a particular disease) and then developing immunity to that disease. Vaccination is the actual procedure of giving the vaccine (regardless of whether the injection or oral substance is successful in making the person immune to the specific disease). When someone receives a vaccine their body in most situations produces a response similar to what would happen if they contracted a very mild form of the disease. Antibodies are normally produced and these circulate in the blood stream. Then, if the vaccinated person ever comes in contact with the disease, the specifically produced antibodies will recognise something foreign and fight it. There is a presumption that if an individual has received the appropriate vaccinations for their age, and according to the suggested schedule, they have been immunised.

Vaccines can contain a small dose of a live non-harmful form of virus, a small dose of killed bacteria or a small dose of a modified toxin. They may also contain some preservative or a small dose of antibiotic. The immune response from vaccination is not immediate and many vaccines have to be given several times before an immunity is built up. Some vaccines have to be given as boosters several times after the initial course. Others give adequate protection during childhood when the disease can be life threatening but are not routinely given to adults. Immunisation has an advantage over corresponding natural diseases because it provides protection without the person having to suffer a clinically diagnosed bout of the disease.

Diseases Children are Vaccinated Against

The current recommended child immunisation schedule involves vaccination against the following eight infectious diseases -- diphtheria, pertussis (whooping cough), tetanus, poliomyelitis (polio), haemophilus influenza, measles, mumps and rubella (German measles). These diseases are serious and their spread through the community can have, and have in the past, caused many deaths and permanent disabilities.

Diphtheria is an acute illness which primarily affects the upper respiratory system. An inflammatory discharge forms a greyish membrane in the upper respiratory tract which then causes severe respiratory obstruction. The diphtheria bacteria produces a poison which can spread throughout the body and cause serious complications such as paralysis and heart failure. Even if treated diphtheria can be fatal. Diphtheria is spread via droplet infection (through coughs and sneezes).

"unforgettable 'whoop' sound"

Pertussis (whooping cough) is a serious, highly contagious disease which is especially dangerous for babies and young children. It affects the airways, making breathing for the sufferer very difficult, and is characterised by repeated bouts of coughing which make the unforgettable 'whoop' sound as the individual draws air into the lungs after coughing. Pertussis can be lethal or it can lead to complications some of which include convulsions, haemorrhage, coma, inflammation of the brain, permanent brain damage, pneumonia, hernia and long-term lung disease. Pertussis is spread via droplet infection.

Tetanus can be a fatal disease. It affects the nervous system. It causes painful muscle spasms of the neck and jaw which can lead to breathing difficulties, convulsions and abnormal heart rhythms. Tetanus is caused by a toxin produced by *Clostridium tetani* which is present in soils, dust and manure. It is not spread from person to person. The tetanus toxin can enter the body via the smallest wound.

Poliomyelitis (polio) is a virus which can affect the digestive and nervous systems. Mild symptoms caused by the polio virus include vomiting, fever and muscle stiffness. Severe polio affects the nerves and can cause permanent crippling. Paralysis of the breathing and swallowing muscles can lead to death. Polio is transmitted when the faeces of an infected person contaminates food, water or hands. There appear to have been no documented cases of classic polio in Australia for many years, but easily accessible travel means that there is always the threat of an outbreak.

Haemophilus influenza in the past has been the most common cause of life threatening infection in young children. Haemophilus influenza can declare itself in several ways. It can cause swelling in the throat which can obstruct breathing (epiglottitis), infection of the membranes covering the brain (meningitis), infection of the tissue under the skin (cellulitis), pneumonia and joint infection. If left untreated meningitis and epiglottitis can cause death in a very short time.

Measles is a highly infectious, acute viral illness which causes runny nose, fever, rash, cough and sore red eyes. In some individuals measles

can lead to serious complications such as pneumonia and inflammation of the brain. This inflammation of the brain can lead to permanent brain damage or death. Measles is spread via droplet infection.

Mumps is a disease which primarily affects children between the ages of 5 and 9 years. It causes inflammation of glands (particularly the salivary glands), fever and headache. Occasionally it can cause inflammation of the brain or permanent deafness and sometimes inflammation and swelling of the testicles can lead to infertility. Mumps is transmitted via droplet infection.

Rubella (German measles) is a relatively mild infectious disease which can manifest itself by a rash on the face and neck, swollen glands and joint pains. Rubella as a disease is not to be feared but it can be very dangerous if a pregnant woman (20 weeks or less) catches it. Rubella can cross the placenta and affect the foetus during its developmental stage. Abnormalities caused by rubella include intellectual disabilities, blindness, deafness and heart defects. Rubella is also transmitted via droplet infection.

The Schedule

Diphtheria, pertussis and tetanus vaccines are usually combined together and given as one injection in small children — DPT. In older children and adults the vaccine does not include pertussis and is known as ADT. The pertussis vaccine can be given separately if needed. The DPT is given at 2 months, 4 months and 6 months with a booster dose at 18 months and 4-5 years (usually when the child is in prep class). The ADT booster is given at 15-19 years and theoretically every 10 years after that. There is really no reminder scheme after the adolescent booster but adults with a deep or dirty wound should be advised by health professionals to have a tetanus toxoid injection.

Polio vaccine is given as droplets by mouth at 2 months, 4 months, 6 months, 4-5 years and 15-19 years. Haemophilus influenza vaccine (Hib) is administered as an injection and is usually given at the same time as the DPT at 2 months, 4 months, and 6 months, sometimes with the measles/mumps/rubella (MMR) at 12 months or the DPT at 18 months. The Hib vaccine is a relatively new inclusion on the schedule (1993), and there are a few different vaccines on the market, which accounts for why Hib may be given either 3 or 4 times. The first dose of the MMR injection vaccine is given at 12 months with a second dose at 10-16 years. Initially only girls were given the rubella component, but as vaccination does not necessarily mean immunity there were still risks of males transmitting the disease to vaccinated but unimmunised pregnant women, which would risk the health of their unborn babies. Currently, boys and girls are both vaccinated, and women who are considering becoming pregnant are advised to have their blood checked for antibodies. Then, if their antibody level (titre) is low or non-existent and they are not already pregnant, it is suggested that they have another rubella vaccination to minimise the risks of foetal damage.

There are contraindications to the administration of vaccines. Children with certain diseases, children who have had documented severe reactions in the past or children who are on certain medications should not be vaccinated according to the suggested schedule. The medical vaccination provider should not vaccinate the child on the scheduled date and in some cases certain vaccines should not be given. These contraindications are well documented in The Australian Immunisation procedures handbook produced by the NHMRC (National Health and Medical Research Council). It is the responsibility of the vaccination providers to keep up to date with this information and to advise parents or guardians about even minimal side effects and suggest any necessary treatment.

Vaccination — Efficiency and Consequences

Immunisation against the previously mentioned childhood infectious diseases is an effective way of minimising the numbers of children and in some cases adults, who either die or are severely incapacitated from the effects of these diseases. Some vaccinations can offer almost total immunity to a specific disease while others such as pertussis are effective in controlling the spread of the disease but do not eliminate it. An individual can still contract a disease even though they may have been vaccinated against it but they will

"must be analysed in light of the chance of contracting the disease without vaccination"

get a milder form than if they had not been vaccinated at all.
The administration of vaccines is not without its risks, but these must be analysed in light of the chance of contracting the disease without vaccination. Most of the side effects or adverse events that manifest themselves following a vaccination episode are relatively mild. These may include localised swelling and redness at the injection site, an elevated temperature, crying and irritability, malaise and a rash. It is obviously distressing for a parent to see their child suffering from any of these events, but it would be far worse to stand by helplessly as they gasp for breath with whooping cough or diphtheria.

There are, however, some adverse events which may occur following vaccination which are more serious. These may include allergic reactions (very rare but can be treated immediately), seizures, very high temperatures and brain damage. The actual pertussis disease is 100 times more likely to cause brain disease than the vaccination. It is the pertussis vaccine which has gained the most controversy in relation to serious adverse events, but no actual

causal relationship has been determined between its administration and chronic neurologic abnormalities. A long term study performed in Britain and reported in the journal 'Pediatrics' looked at the temporal association between immunisation and the onset of the neurologic disorder. "... the role of DTP immunization as a prime or concomitant factor could not be determined in any individual case, and some cases may have occurred by chance or had alternative causes." Despite this scientific evidence those who oppose immunisation programs are not convinced and put forward emotive, anecdotal claims to support their position. While no-one wants to trivialise a tragic event such as a child developing brain damage (by chance following vaccination) or deny that for that family having a sick child is far more grievous than an epidemic affecting 'other' people, the benefits of mass immunisation cannot be over estimated.

The polio vaccine has also been mentioned in relation to serious side effects — in this case the actual contracting of paralytic poliomyelitis following vaccination. While this perhaps should not be overlooked, one needs to look at the statistics. The incidence of paralytic polio following vaccination is reported as 1 per 3,000,000 doses of the vaccine, whereas prior to routine vaccination in Australia (commenced in 1956) the peak incidence of poliomyelitis was 39.1 per 100,000 people in 1938. These statistics cannot directly be compared but the fact that there have been only 3 notified cases of classic polio since 1978 (2 cases in 1978 and 1 case in 1986) supports routine vaccination. The risk of contracting vaccine induced polio would seem to be far less than the risk of contracting the disease in an unimmunised population.

Rates of Vaccination and Data Collection

Currently, Australia has an abysmal vaccination record according to health department officials and the media. Many statistics have been used to highlight our failure to vaccinate, but these figures need to be analysed in view of what they actually represent. The Australian Bureau of Statistics (ABS) conducted

"no central register that contained information on vaccination rates"

surveys in 1989-1990 and 1995 to obtain information on childhood immunisation and health screening. The surveys were conducted to determine the number of fully immunised children in Australia. Full immunisation against a particular condition for the purpose of the ABS surveys referred to whether the child had received the number of vaccinations for that condition appropriate for their age as specified in the Immunisation Schedule. It is these ABS results which seem to be used in discussions of vaccination rates in the media. Given that at the time of these surveys there was no central register that contained information on vaccination rates, it is hardly surprising that interviewing parents was the method used to gather the data. In some instances personal vaccination records for a particular child were used to validate a parent's memory, but this was not always the case, and even when used, the records were not stringently checked. As evidenced earlier in this paper, the vaccination programme involves the administration of many vaccines over a period of many years during which there may be changes to the program. It would not be surprising therefore to conclude that a parent's memory may not be entirely accurate, especially if there were several children in the family. Some studies have actually found that parental recall has been shown to overestimate vaccination coverage. This particular finding is worrying, especially if up until recently parental record was the most accurate available method of determining vaccination rates. It should also be mentioned that some citations of the vaccination rates do not include the rates for all the vaccinations on the schedule.

This inaccuracy in gaining and recording vaccination data has not gone unnoticed. On the 1st January 1996 The Australian Childhood Immunisation Register (ACIR) came into existence. This acts as a record of vaccination for children aged from birth to 6 years. Such details as name of vaccinator, Medicare number, manufacturer, batch number of vaccines administered and date of vaccinations will be recorded. It is the vaccine providers' responsibility to provide this information. The Register will also operate as a reminder system for parents when vaccinations are due. Any child enrolled in Medicare will be included on the Register. The ACIR is a welcome improvement to the status quo of national data collection and vaccination reminders.

In the following bulletin I will be discussing who should have the responsibility for immunisation, the possibility of compulsory vaccination and new strategies for boosting Australia's vaccination rate.

✣

Deirdre Fetherstonhaugh

Sources

Australian Bureau of Statistics, *Children's Immunisation*, No. 4352.0 April 1995.

Commonwealth Department of Health and Family Services - Robert Hall, *Immunisation myths and realities: responding to arguments against immunisation.*, Australian Government Publishing Service, Canberra.

National Health and Medical Research Council, *The Australian Immunisation Procedures Handbook*, Fifth Edition, 1994.

Committee on Infectious Diseases. "The Relationship Between Pertussis Vaccine and Central Nervous System Sequelae: Continuing Assessment" *Pediatrics*, 97 No. 2 (1996) 279-281.

Suicide in Young and Old is a Challenge for Society

Recent medical attention has focussed on the increasing rate of youth suicide, but suicide is a growing problem for all age groups in our community. It is a problem on which we need to work together in order to solve.

Suicide and Related Behaviour

According to most sources suicide is on the increase. In particular, recent attention has focused on youth suicide. Unfortunately though this is not the only age group with which we should be concerned. Australia's rate of suicide is reported to be amongst the highest in the industrialised world. Statistics like this do not paint an optimistic picture. It is extremely difficult to compare suicide rates between countries and across generations. The problem arises in attempting to define suicide and what evidence there must be for a death to be classified as a suicide. The word suicide itself comes from Latin. '*Sui*' means 'of oneself' and '*cidium*' which means 'slaying'. The term is now generally understood to involve the conscious decision to end one's own life. The difficulty rests in determining exactly what acts of deliberate self harm should count as suicides, and what other risky behaviours should be considered suicidal. Alternative definitions of suicide as well as requirements of evidence of intention are used in different countries. This means comparing the suicide rates of different nations is only of limited value. In any case, the suicide rate is too high. The rate of suicide is of major concern, but equally concerning should be risk-taking behaviours where people involved do not care if they risk their lives. A lack of concern for one's own continued existence is closely related to intentionally taking one's own life, and both areas of behaviour require preventative action.

A Growing Phenomenon

It is frequently reported that male youth suicide has increased by roughly 300 per cent over the past 30 years, while the rate of female suicide has remained static. This apparent rise in suicides is alarming. The extent of the actual increase in suicide over several decades however, is difficult to identify. One reason for such a giant increase is the fact that in the 1990s suicide no longer has the stigma attached to it that it once did and coroners are more willing to classify a death as suicide than their counterparts were in the 1960s. More recent trends in suicide indicate that the practice of suicide is increasing and remains a problem for the entire community. The suicide rate in Australia for males, across all age groups, is almost five times that of females. Often it is the young males' suicide rate which is the focus of much attention, while in reality all areas of suicide and related behaviours are in need of attention.

"the practice of suicide is increasing"

Female suicide is only recently on the increase. In Victoria in 1994, 57 females suicided in the 15-24 years of age group, and in 1995 the number jumped to 84. An annual increase of 48% is alarming. For the same periods and age group male suicides decreased from 374 to 350 (6.4%). With four times more males suiciding than females it is not surprising that male suicide claims about the same number of lives as road accidents. However, suicide prevention shares neither the attention nor concentration of resources that the prevention of road accidents receives. Statistics such as these go only part of the way in describing the current situation regarding suicide. Many actual suicides are not recorded as suicides because they may have been classified as accidental deaths or the cause of death has simply been left undetermined. Also included in the picture should be the high number of attempted suicides and the high rate of risk-taking behaviour exhibited especially by young people, but both these behaviours are difficult to quantify. **Clearly there is a crisis when across the community the number of people deciding to end their lives is increasing**. Before providing funding for suicide prevention the areas where spending would be most effective need to be identified. Prevention strategies must focus on the risk factors and causes of suicide as well as the environment in which suicide appears to be thriving.

Focus on Youth Dangerous

Adolescence is not a new phase of growing up. It is a part of life through which all those who reach adulthood have passed. At the moment most concern is focused on why young people, especially those aged between 15 and 24 years, are committing suicide at numbers in excess of 500 per year in Australia and attempting suicide at an even higher rate. It is a sad reflection on our society that so many people feel they have no alternative but to end their lives. Suicide in many instances is used as a solution to a problem that the suicidal person has no other way of dealing with. It may be a problem-solving technique for the individual who kills themselves, but a suicide causes heart ache and suffering for everyone left behind. It is tragic that youth suicide is increasing, but at the same time it is important to realise they are not the only group in our community with a growing rate of suicide. All age groups of males in Australia have

"males aged 75 years of age had the highest rate of suicide"

seen an increase in their suicide rates, and in 1993 it was males aged 75 years of age and over who had the highest rate of suicide with 30.46 per 100,000 of population, 94 deaths. Other worrying figures include 28.73 completed suicides per 100,000 of the population in the 25 to 34 years age group, resulting in 406 deaths. Young males in the 15 to 24 years age bracket had the third highest rate of suicide with 24.62 per 100,000 of the population, a total of 345 deaths. It **is** important to concentrate on young people, but suicide in general should be of major concern with 2367 deaths from suicide and self inflicted injury in 1995.

Risk Factors and Causes not Enough

In attempting to comprehend the increase in the number of suicides and related behaviours it is essential to try to understand why people take their own lives, or try to deliberately harm themselves in life-threatening ways. Attention should also be focussed on why males complete suicide more than females, and what, if any, are the warning signs and the effectiveness of current prevention

"children and adolescents have grave concerns about the world they will inherit"

strategies. Attempts to understand are to be encouraged and admired, but there may be a deeper problem than might be first realised. Something is different about not only the young people of today but the whole of society that might be at least partially responsible for the climbing suicide rate of young people and their general pessimistic and cynical view of their future and that of the world. Surveys show that children and adolescents have grave concerns about the world they will inherit. Comparing suicide rates should include comparing the society of the time. In the 1960s the 'baby boomers' were in their youth, they had a sense of hope for the future, of being better off than their parents and enjoying life. Society had strict morals, the world seemed safe, and there was a shared vision of the future, the rate of suicide for males was around 8 per 100,000. In the 1990s it is 'Generation X' who are in their youth. According to most reports they will be the first generation not to be better off than their parents and the planet they inhabit is undergoing rapid environmental decay. Young people today are experiencing rapid change which is creating unstable personal and social environments. This is further compounded by the detailed information they receive about the very real and grave problems that involve both their local environment and the world at large.

We live in the age of science and technology. The result is a world view that is more rational, reductionist and mechanistic than at any time before. The focus of society has shifted. The age of materialism is alive and well. There exists an unhealthy preoccupation with possessions, beauty, sex lives and careers. Facts are more important than values, and as a consequence the spiritual or transcendental dimension of our lives has been lost. The male suicide rate for the 1990s is around 25 per 100,000 of population. More on the spiritual aspect of suicide can be found in Dr. Mary Stainsby's article in the Autumn 1996 edition of the Centre's bulletin titled, "Youth Suicide and Suicide Prevention".

Suicide a Personal Solution to Social Problems

Suicide is definitely an issue society should be concerned about, but it is not strictly a social problem. Studies detail a long list of risk factors associated with suicide and include: unemployment, mental illness, substance abuse, ethnicity, rapid social change, the breakdown of the traditional family unit, loss of a loved one through either death or rejection, fear of failure and the ever-increasing use of technology that has depersonalised communication. The majority of identified risk factors are social problems that impact differently on individuals depending on their personality, intelligence and the social context in which the problem presents itself. Suicide is often an individual's way of dealing with one or more social problems. Strategies for suicide prevention should include an attempt by society to change the incidence of the social 'risk factors' in an attempt to create an environment where suicide is no longer seen as a solution. It is here that suicide prevention could begin and possibly be most effective. There is not a quick or easy solution to suicide. In

'there is not a quick or easy solution to suicide"

fact suicide is such a personal issue that the only assistance the community may be able to provide is establishing a society in which pressure, expectations and differences are dealt with more successfully than they are at present. Young people, with the help of appropriately trained educators, need to be properly prepared for the pitfalls of life. Failure and rejection are experiences that if dealt with successfully can make one a better person.

United Effort Needed

A recent study by the child and adolescent psychiatry unit at the Western Hospital criticises both teachers and GPs alike in their failure to accurately identify 'at risk' young people or follow through with adolescents whom they identify as troubled. These two groups of professionals should not be alone in shouldering blame. Adolescence is a difficult phase of growing up. It is up to everyone who is involved in the lives of young people to help them through this phase and prepare them properly for adult life in the community. Young people should not have to rely solely on their teachers or doctors, whom they must themselves seek out when in need of support and back up. Family, in whatever form, friends and the general community should all be responsible for providing support and assistance for young people. Looking for prevention once a young person is suicidal is a delayed response to a problem which

has by that time reached crisis point. It would surely make more sense to look at preventing people needing to consider a solution as dramatic and final as suicide. Suicide prevention

"people need to feel valued"

strategies need to focus on more than preventing completed suicides. They need to find ways to eliminate suicide as an option for people. Preventing people from contemplating or attempting suicide will be very effective in preventing deaths from suicide. Instilled in everyone should be a sense of self worth irrespective of their social standing, job situation or popularity. People need to feel valued and, no matter how desperate a situation appears to be solutions other than suicide are available. Society and religious organisations need to provide young people with the skills and self understanding that life in the 1990s demands. This would ensure a decrease in the suicide rate of the entire community in future generations.

✣

Tracey Scott

Sources

Commonwealth Department of Health and Family Services. *Youth suicide in Australia: a background monograph* 1995.

Murray, David, & Tehan, Maree. *Signs of hope: A Catholic health care response to youth suicide.* 1996. A Report commissioned by the Australian Conference of Leaders of Religious Institutes.

The Age 9th November 1996.

The Sunday Age 26th January 1997.

Dying with Dignity: The Right to Refuse Medical Treatment in Australia

This article is written in the light of the current controversy about euthanasia and follows the discussion in the last issue of the Bulletin on Victoria's Medical Treatment Act. In this article I look at the right to refuse medical treatment in Australia, both at common law and by statute in South Australia and the ACT. The Northern Territory will be discussed separately in a later issue.

Introduction

In the last few months, in the light of the Northern Territory euthanasia legislation there has been much legal and ethical debate in the media, both about a patient's right to refuse medical treatment, and the right of others to refuse treatment for an incompetent patient.

The law in Australia is developed through the doctrine of precedent. Precedent refers to the rule that past judicial decisions should be followed in future cases, based on either the common law or on legislation. "Common law" is law that has always been in place, developed by judges and the court system over hundreds of years. Legislation is created by Parliament and then interpreted by judges.

In Australia the laws on the right of a patient, or a patient's representative, to refuse medical treatment differ from State to State: the parliaments of Victoria, South Australia, the ACT and the Northern Territory have enacted legislation to cover the right to refuse medical treatment. In Queensland, New South Wales, Tasmania and Western Australia the issue is still governed by common law: throughout this article, a reference to the common law means that this is the law of these States.

Common Law Right to Refuse Treatment

There has always been a common law right in Australia to refuse unwanted medical treatment, even if that treatment will 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. This means that doctors are open to be sued for trespass or assault if they continue with treatment contrary to a patient's wishes.
However, in some situations where

"at common law one cannot consent to one's own death"

treatment is withheld at the patient's request and death results, the issue of whether or not an unlawful killing has been committed cannot be entirely free from doubt. This is because at common law one cannot consent to one's own death: this has also been encoded in statute in Queensland, Western Australia and Tasmania. Therefore, although it could, for example, be considered an assault to sustain a person on life support contrary to their express wishes, their consent to its removal would not provide justification against criminal prosecution if it could be proved that the *doctor* had caused the death.
It has been argued that withdrawing

"in many situations the law simply holds to 'accepted medical practice'"

life support machinery is not the real cause of death and that it merely allows the existing fatal condition to operate naturally. However, in spite of this, the law on the question of removing a patient from a life support machine is still in doubt. Because it is based on the doctrine of prece-

dent, the common law has not kept pace with modern technology. In many situations the law simply holds to "accepted medical practice", thus leaving difficult decisions in the hands of doctors.

Due to the uncertain nature of the common law, some States have enacted legislation to cover this difficult area.

South Australian Medical Treatment and Palliative Care Act

In 1983 the South Australian *Natural Death Act* was the first of its kind in Australia, enshrining as it did the right to direct that extraordinary measures for prolonging life be discontinued. In 1995 the *Natural Death Act* was repealed and replaced by the *Consent to Medical Treatment and Palliative Care Act* which has widened the scope of the original act.

This act allows for anyone over the age of 16 to "decide freely for themselves on an informed basis whether or not to undergo medical treatment" (s.3(a)(i). While the act does not specifically say that a person may refuse medical treatment, it does say that a person over 16 "may make decisions about his or her own medical treatment" (s.6).
It also clarifies the legal situation of

"a doctor will incur no liability for either an act or omission done with the consent of the patient or the patient's representative"

a doctor, saying specifically that a doctor will incur no liability for either an act or omission done with the consent of the patient or the patient's representative (s.16). In addition, in the absence of directions to the contrary by the patient or the patient's representative, a doctor is "under no duty to use ... life sustaining measures in treating the patient if the effect of doing so would be merely to prolong life in a moribund state" (s.17(2)).

ACT Medical Treatment Act

Under the ACT's *Medical Treatment Act 1994* a person must be 18 in order to refuse treatment, the refusal must be for a "current condition" and must be witnessed by two health professionals (s.6 and s.8). In addition, a health professional is not to give effect to the direction unless they believe that the person refusing treatment has understood the nature of their illness and has weighed all other options (s.11). A health professional must not withdraw treatment if this is at all in doubt (s.12). If a health professional relies on a valid refusal of treatment, then they are not guilty of any offence in connection with the withholding or withdrawing of treatment (s.22).

NSW and SA Guidelines

While New South Wales and South Australia have not legislatively dealt with the issue of refusal of medical treatment, the common law is supplemented in these two States by "Guidelines", produced by their relevant Health Departments. The guidelines claim that "health professionals who apply these guidelines, in conjunction with the accepted clinical standard of their peers, armed with accurate information and adequate consultation, should feel confident to make the decision to withhold futile treatment".

The guidelines are based on the principles of respect for human life, patient autonomy, consultation (including consultation with the patient's family), access to health care and professionalism. They outline that patients need to be fully informed as to proposed treatments or withdrawal and "as far as possible make a choice themselves". The patient has the right to refuse any treatment and health care professionals must respect the rights of all patients to make decisions regarding their care. In the case of an incompetent patient, while families should be consulted and their wishes followed as much as possible, decisions should still be made at the discretion of the medical officer and in the best interests of the patient: "The ultimate responsibility for medical decisions made rests with the responsible attending medical officer".

Emergency Treatment

In emergency situations the doctrine of necessity is recognised at common

"in emergency situations the doctrine of necessity is recognised at common law"

law: this means that the usual principles governing consent are not applicable to emergency situations where immediate treatment is necessary. An unconscious person does not need to give consent to medical treatment where lack of it would result in death. In such situations, although there is no legal requirement for a hospital to require the consent of relatives to treat unconscious patients, it is often policy in individual hospitals to request it.

The doctrine of necessity is not mentioned in the ACT legislation. This means that common law still applies on this issue. However, emergency treatment has been encoded in the South Australian statute. It outlines that a medical practitioner may lawfully administer medical treatment if there is imminent risk to life or health and the patient "has not, to the best of the medical practitioner's knowledge, refused to consent to the treatment" (s.13(1)).

Pain Relief

In the ACT the right to refuse medical treatment does not include a right to refuse palliative care (s.5(2)), defined as "the provision of reasonable medical and nursing procedures for the relief of pain, suffering and discomfort, and the reasonable provision of food and water". In addition, the *Medical Treatment Act* outlines that a patient has a right to receive pain relief "to the maximum extent that is reasonable in the circumstances".
If a patient's disease progresses beyond the point where treatment can

cure it they may be given morphine at very high doses to relieve the pain. In some situations this may have the inadvertent result of shortening life. At common law, pain management of this kind would not be regarded as the cause of death.

This has been encoded in the South Australian legislation, with s.17(1) outlining that a medical practitioner who administers medical treatment with the intention of relieving pain or distress does not incur a civil or criminal liability, even though the treatment may hasten death.

Advance Directives and the Right of Agents to Refuse Medical Treatment

Community concern about who makes decisions for people who become mentally incapable, for varied reasons, has led to the introduction of the concept of the "enduring power of attorney". In New South Wales, Queensland, Tasmania, Northern Territory and Western Australia an enduring power of attorney can only be issued to deal with property. Like Victoria however, in South Australia and the ACT special provisions have been made for a *medical* power of attorney.

South Australia's legislation outlines

"a medical power of attorney entitles the appointed agent to make decisions about medical treatment on behalf of the patient"

that a person must be over 18 and of sound mind in order to create a medical power of attorney. The power of attorney must be in the form set out in the *Consent to Medical Treatment and Palliative Care Act*. It entitles the appointed agent to make decisions about medical treatment on behalf of the patient if at some stage in the future the patient becomes incompetent. However, the agent is *not* allowed to refuse the "natural provision" of food and water, nor the "administration of drugs to relieve pain or distress" (s.8). The expression "natural provision of food and water" is an interesting addition, implying that although food and water may not be refused, intravenous feeding may be.

S.13 of the ACT's *Medical Treatment Act* says that a person may "confer on another person the power to consent to the withholding or withdrawal of medical treatment in the event that the grantor becomes incapacitated". The agent may only request the withdrawal of treatment if they believe on reasonable grounds that the grantor of the power of attorney would have requested withdrawal in that situation (s.16(1)(b)).

While the New South Wales and South Australian departmental guidelines do not recognise the enduring powers of attorney, they do recognise the concept of "advance directives". These are directives for future care that are given by the patient where the patient outlines the type of treatment they would like to receive, or have withdrawn if at some future date their illness reaches a particular stage. The advance directive must be prepared "contemporaneously" with the illness and should be periodically reviewed and updated. Medical officers are entitled to rely on a properly prepared advance directive unless "the clear purpose would be to shorten life".

The South Australian act also allows for advance directives from a person over 18, but the directive must be in a form outlined in the act and is only allowed to give a direction about medical treatment in the event that at some future time the person is "in the terminal phase of a terminal illness, or in a persistent vegetative state" (s.7(1)).

The ACT act does not allow for or recognise the principle of advance directives.

Conclusion

Like Victoria's *Medical Treatment Act* discussed in the last issue of the *Bulletin*, the rationale behind both the common law and statutory law is to protect the patient's right to avoid being burdened with futile treatment. Statutory law also protects the doctor from prosecution. However, it is important to recognise that, apart from the situation in the Northern Territory, Australian 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. ✣

Anna Stokes

Sources

Dix, Andrew, et al.(eds) *Law for the Medical Profession in Australia.* Melbourne:Butterworth-Heinemann, 1996.

Lanham, David. "The Right to Choose to Die with Dignity", *Criminal Law Journal* 14 (1990) 401.

Lanham, David & Susan Woodford: "Refusal by Agents of Life-Sustaining Medical Treatment" *Melbourne University Law Review* 18 (1992) 659.

MacFarlane, Peter. *Health Law: Commentary and Materials.* Sydney: The Federation Press, 1995.

Mason, JK & McCall Smith, RA. (eds) *Law and Medical Ethics.* London: Butterworths, 1994.

Medical Treatment Act 1994 (ACT).

Medical Treatment and Palliative Care Act 1995 (SA).

Mendelson, Danuta. "Medico-Legal Aspects of the 'Right to Die' Legislation in Australia" *Melbourne University Law Review* 19 (1993) 112.

Tasmanian Dying with Dignity Working Group: *Dying with Dignity: Draft Interim Guidelines* Community and Health Services, Tasmania, 1994.

The Human Person and Life's Journey

To deal successfully with people account must be taken of each one's personal situation - their subjectivity, hopes, worries, faith, human nature, age, health and their attitude to sickness and the approach of death.

The human person does not exist in the abstract without a name, family relationships, a personality, a nationality, a culture, a state of health, an age and a religious faith or a system of beliefs and values. To touch one's culture or basic beliefs is to touch the person. Health carers and pastoral workers need to understand the nature of the human person and the stages of life's journey if they are to improve their integral professional service to their patients.

Human Person Known through Experience and Reflection

The human person may be considered in the light of reflection on experience, reason and the Christian Faith. We experience ourselves in a variety of ways through our feelings, pleasures, pains, growing up, marriage and family life, community relationships, recreation, social and political life and cultural activities. Personal worth should be experienced in the secret intimacy of the mind and heart. We resent unnecessary and depersonalising invasions of our privacy be they blatant or ever so subtle. Modesty itself loudly proclaims our personal dignity when it bids us to clothe our bodies to show that the person cannot be reduced to any part of the body.

We strive after happiness yet frequently we are frustrated, crave personal friendships yet find we are rejected or made neurotic through the din and tyranny of the invading crowd. We seek a personal transcendent God yet we are immersed in a materialistic world of self-indulgence, greed, cynicism and violence. We struggle to be virtuous and to promote the happiness of others and we fail. Suffering and death are inevitable but reason fails to explain why this is so even though it can provide grounds for believing in personal survival after death. This, in its turn, depends on rational arguments for the existence of an almighty, wise and good God.
We identify with ourselves in a special way when we make sincere

"we are subjects of intrinsic worth who may not be used as mere means for others' ends"

judgements about the truth, especially when we make important judgements of conscience. The importance of the truth gives rise to a sense of responsibility which requires us, among other things, to take reasonable care of our health. Likewise the exercise of free will is highly valued and reveals our personal dignity most of all when we submit to the summons of conscience demanding that we do good to be true to ourselves as personal beings. We are aware of ourselves as subjects of intrinsic worth and inestimable dignity, the centre of our world, who may not be used as mere means for others' ends.

We are aware of our responsibility to become more personal beings through acts of free choice. This is an aspect of our personal dynamism whereby we are ever engaged in a search for happiness and self-realisation. We know that we are moral agents. As relational beings we cannot be complete or achieve fulfilment except by communicating with others through knowledge and mutual love. It seems our personal dignity and absolute value is based on our natural capacity to seek and enjoy genuine and permanent happiness.

Notwithstanding the great variety of our experiences of body and mind, we recognise that they all equally belong to one personal subject of human existence. Our primordial and basic awareness is of a self who is a complex being, one subject of both bodily and rationally self-conscious and free acts. We recognise other humans as equal to ourselves in dignity, superior to animals, plants and things. We see ourselves primarily as persons before being men or women, husbands or wives, doctors or nurses, employers or employees.

Human Person Known through Reason

The human person has to be considered as a whole in relation to all that pertains to human nature and integral human experience. It is by inductive reasoning, based on experience and guided by the light of sound philosophical principles, that we can acquire an understanding of the human person. The human person must not be conceived as something purely biological and unchanging. Though essentially personal and the same for all, human nature is somewhat dynamic as its significance gradually unfolds throughout history in various nations and cultures. Our moral concepts are based on human nature as the principle of personal acts. We ever interpret anew what is good for persons on the basis of the available evidence and of our expanding knowledge of ourselves and our place in the world.

The inevitable presence of defects and aberrations in natural functions and processes does not mean they are natural. It is both a challenge and a risk to discern what is truly defective and pathological and what is naturally and morally good. What is artificial might not be natural. This does not matter so long as something is not unnatural and contrary to the integral good of persons. It is not the task of right reason to invent, but to discover and formulate afresh a personalised account of the natural moral law.

The foundation for all our human experiences, capacities and human personhood is found in the human nature

"the foundation for human personhood is human nature"

of each individual. The nature of the cat or dog does not enable them to have the rationally self-conscious activities of humans or to live personal lives. Human nature includes a body and soul, a material and a non-material principle, which somehow together constitute us as living human individuals and enables us to perform rationally self-conscious personal acts.

Philosophers like Peter Singer do not accept that it suffices to be an individual member of the biological species *Homo sapiens* to count as a person. They require some minimal experience of oneself as a personal being of dignity and value and who has some desire to attain happiness and self-fulfilment. The active capacity for exercising some minimally self-conscious rational acts must have already been acquired before conceding the developing human individual is a person. It is necessary to bear in mind this restricted meaning of the term 'person' employed by these contemporary philosophers in order to avoid serious misunderstandings. Other philosophers, including myself, following a long western tradition, hold that a living individual with a human nature is a person precisely because he or she is the real subject in which personal acts inhere. A human fetus or a newborn infant, then, is a person with potential, not a potential person.

Christian Perspective on the Human Person

The Christian Faith complements the findings of reason on our dignity and destiny as persons. Our Faith teaches that in addition to our parents' love, we owe our being to the creative act of God who willed us into existence to share his life and happiness. We are not to behave as absolute masters, but responsible stewards of our natural endowment and environment in the pursuit of our goals.

As a result of sin from human beginnings, human reason has been clouded, resulting in our inability to find out with certitude all the moral principles required for human flourishing in our personal and social lives. Christ gave us an example of how to satisfy the demands of the love of God and of neighbour in our daily lives.
Being a Christian does not make any undue imposition on, nor detract any genuine value from, our humanity.

"being a Christian does not detract any genuine value from our humanity"

Christ is no outsider. He is truly one of us and of our stock. The Christian Faith holds that our fallen humanity was restored in the mystery of Christ. As the Vatican Council said: "Whoever follows Christ the perfect Human Being, becomes himself or herself more a human being." We can learn much about the meaning and destiny of ourselves from the life of Christ "who fully reveals the human person to himself/herself".

Disease and Sickness

On account of the presence of sin from the beginning of human history and our own personal sins we are not exempt from our share of sickness, suffering or disease. The stark reality is that, notwithstanding the best of medical treatment and the use of pain killers, at times suffering has to be endured patiently. Jesus showed his compassion for the sick and cured them as a sign that the Kingdom of God was already being ushered into the world. Health carers imitate the goodness and compassion of Christ by restoring the sick to good health.

The Christian faith helps believers accept suffering serenely. In a spirit of faith St Peter reminded the early Christians and ourselves that what God did for Jesus he will, in His own time, do for us -- change suffering into glory: "But rejoice in so far as you share Christ's sufferings, that you may also rejoice and be glad when his glory is revealed (I Pet 4:13)."

Dying and Death

Most people find the prospect of death quite threatening. We can hardly endure the thought of leaving our loved ones and letting go of our grip on this world. Our sense of personal dignity rebels against death in spite of medicine's power to delay its inevitable approach. In the words of the Vatican Council, comfort and support are provided by the Christian faith: "The Christian faith teaches that bodily death, from which man would have been immune had he not sinned, will be overcome when that wholeness which he lost through his own fault will be given once again to him by the almighty and merciful

"sickness,suffering and death cannot be absolute evils for Christians"

Saviour." This is why sickness, suffering and death cannot be absolute evils for Christians.
✣

Norman Ford SDB

Sources

Second Vatican Council, *Gaudium et Spes, Pastoral Constitution of the Church in the Modern World,* nn. 18, 22 and 41.

Norman M Ford SDB, *When Did I Begin? Conception of the Human Individual in History, Philosophy and Science*, Cambridge: University Press, 1988, p/b 1991; *Live out the Truth in Love*, Melbourne: Catholic Education Office, 1991.

P. Singer, *Practical Ethics*, 2nd. ed. Cambridge: University Press, 1993; *Rethinking Life & Death: The Collapse of Our Traditional Ethics*, Melbourne: The Text Publishing Company, 1994, and Oxford: University Press, 1995.

Book Review

Genetic Intervention on Human Subjects. Report of a Working Party of the Catholic Bishops' Joint Committee on Bioethical Issues. London 1996. vii + 88 pp. ISBN 0-9520923-1-X £6.75

This book begins with an up to date exposition of the scientific and clinical aspects of gene therapy and some general moral considerations in relation to human beings and their fulfilment. There follows a brief account of the purpose of medicine and of genetic health and genetic responsibility. There is a full discussion of somatic gene therapy, germ-line therapy and non-therapeutic genetic interventions.

The forms of morally permissible genetic interventions are clearly summarised. Somatic gene therapy, which targets an individual's organs and tissues, is found to be morally permissible in much the same way as other forms of experimental therapy. While germ-line therapy in principle could be morally acceptable, the Report in practice rules it out since it would usually involve the use of *in vitro* fertilisation and destructive experimentation on human embryos in the course of developing the therapy. At present and for the foreseeable future, germ-line therapy would pose undue risks to the human subjects and to their descendants. The outcome of genetic interventions on sperm or egg are unpredictable. Even if one defect were to be rectified, the normal functioning of other genes could be adversely affected. The Report rightly favours the screening of ova followed by the replacement of normal ova and marital intercourse. This option would be morally acceptable as well as being safer.

The Report argues in favour of supporting couples who decide to have children who may be at risk of being conceived and born with genetic defects. It would be morally permissible for couples to decide to avoid conceiving genetically defective children but they should be careful to recognise the value of the lives of people with genetic disorders. It is a pity the Report did not consider the ethical dilemmas (e.g. disclosure to one's prospective partner) confronting people who are affected by a genetic disease or who are carriers and who are thinking about marriage.

This is an excellent ethical resource book for people working in the areas of medicine, health sciences, law, and pastoral care. It would not be too difficult for teachers to use with senior secondary students who are interested in these topics. A glossary of scientific terms is a valuable feature of the book. One appendix discusses legal issues and another contains extracts from relevant Vatican documents.

To order contact; Donald Smith, The Linacre Centre, 60 Grove End Road, London, NW8 9NH, United Kingdom.
£6.75 + 20% for overseas orders p&p.
Fax [0015] 44 171 266 5424 ✣

Norman Ford SDB

Caroline Chisholm Centre for Health Ethics

7th Floor, 166 Gipps Street EAST MELBOURNE VIC 3002
Tel (03) 9270 2681 Fax (03) 9270 2682

EMAIL address: ccche@ozemail.com.au

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

Director/Editor
Rev Norman Ford SDB STL PhD
Adjunct Professor, Australian Catholic University

Research Officers
Deirdre Fetherstonhaugh DipAppSc PGCert BA(SocSc) MA(Health Studies)
Tracey Scott BSc BA(Hons)
Anna Stokes BA(Hons) LLB

Administrative Assistant/Layout
Margaret Casey BTheol