

Rationing Life in the Welfare State

Perspectives on the Future

The 1992 Sir William Liley Memorial Lecture

given by

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Rationing Life in the Welfare State: Perspectives on the Future¹

The 1992 Sir William Liley Lecture was given by Professor Hiram Caton, D.Litt., FAIBiol., on Thursday, July 30 at Women's College, the University of Sydney.

Sir John, Madam Secretary, Honoured Guests, Ladies and Gentlemen.

It is good once again to enjoy the fellowship of Foundation Genesis, and on this occasion I am honoured to deliver the annual Liley Memorial lecture. The Foundation and the Bonhoeffer Institute have collaborated to promote their common cause. It is fitting then that Madam Secretary spoke her memorial on the recent passing of Dr. Daniel Ch Overduin, who inspired the Foundation and the Institute alike. In the last months of his life, Daniel translated the *Dutch Euthanasia Survey Report* into English, making this disquieting document available for our use. It was one of the many services for which he will be remembered and missed.

Rationing life is a jarring thought, but it is now commonplace that the most formidable challenge to health care today is the funding of welfare state entitlements to health care for all. To meet these challenges, there is continuous review of priorities, resource utilisation efficiencies, user pays schemes, closure of hospital beds, and the like.

The unpleasant fact is, however, that gains won through efficiencies are swamped by increasing demands for service and escalating costs. They do not put us ahead, but are a stop-gap against falling too far behind. Since the early Seventies health officials have warned of the impending crisis in health care funding. That talk has continued until, in the past three or four years, OECD Health Ministers have voiced grave concern. In May last the *Journal of the American Medical Association* published another warning. Editor George Lundberg stated that the U.S. health care system

faces collapse in a few years if the cost rise continues at the present rate. He illustrated the point by projecting a national health bill of \$1.4 trillion dollars or 17 percent of the GDP for 1996 on present expenditure rates.

The picture in Europe and Australia is similar if not so grim. The combined annual commonwealth and state health services bill is \$19,000 million or 8 percent of GDP. The National Health Strategy review found last year that health care costs could rise by 44 percent in a decade unless economies are found. Yet membership in private insurance has fallen by 20 percent while the Medicare levy raises only about 6 percent of the total Commonwealth health bill.

A presently favored strategy to meet these costs is to shift them into the user pays modality. Attempts in this direction have not been conspicuously successful, as the experience with the attempted reconstruction of the Pharmaceutical Benefits Scheme showed. The Scheme had blown out to a cost doubling every three years. The government sought to impose a small charge on scripts to encourage discriminating client use. But the charge fell disproportionately on those least able to pay, the pensioners. As one knows, the outcry forced a government retreat, thus returning the problem to the unsolved basket.

Contemplating such indices of disequilibria between demand and supply, one wonders whether the era of the welfare state largesse has crested. Is the crisis in health care funding, and the apparent inability to resolve it, one more signal that we have quietly entered a long period of retrenchment from the comprehensive ethical commitments of the welfare state? If so, the economic presuppositions of the best health care for all will give way to an ethics of care appropriate to an increasingly stringent rationing regime.

The novelty in this scenario is not rationing as such. There is now, as there always has been, a rationing regime whose configuration is traced by identifying those categories of patients for whom demand substantially exceeds supply.

What will change is the horizon of expectation. For about fifteen generations the peoples of OECD nations have experienced a phase of economic, technological, cultural and population growth without historical parallel. This long period of prosperity created a horizon of the future promising that tomorrow will be better than

yesterday.

The post-war period economic boom constructed the comprehensive care of the welfare state on the assumption that it will always be thus. As political parties vied with one another to provide ever better and more expanded services, the public came to regard the best medical care as an entitlement. Best care, we know, has never been extended to all Australians, but the expectation was that it ought to be and would be—sooner rather than later.

This horizon is being retrenched to less buoyant futures consistent with the short-fall between the economic performance of welfare states and their promise. The high visibility given to claw-backs, micro-reform, efficiency, industry shake-outs, and other euphemisms of stringency is the language signaling the transition. Yet pressures from constituencies make it difficult for politicians to maintain a consistent position. Thus the message of permanent retrenchment is diluted to a message of temporary austerity pending the success of economic reform. The public, weary or angry at what they interpret as duplicity or corruption, defect from parties that long enjoyed their loyalty.

The simple truth seems to be that the most affluent economy never has, cannot now, and never will fund the full benefits of the welfare state. One response to this impasse has been the development of a sophisticated cost-benefit tool, called the Quality Adjusted Life Year (QALY), to bring economic efficiency to health services.

The development began some decades ago as an attempt to identify probable therapeutic outcomes of costly procedures.² The strategy was to construct a database of patient populations who had received a specific treatment and whose life course after the treatment was known. The intention was to provide concrete information to assist the selection of the most effective treatment from among the range of options available. The data base would identify where the high probabilities of treatment to desired outcome were occurring, and where the opposite occurred. Moreover, the database yielded estimates of the relative costs of therapy options, thereby adding a cost-benefit dimension to the choice of treatment. The database developed into a distinctive information processing system expanding from individual hospitals to municipalities, to regions and today, on the near horizon, national and even international health systems.

In recent years longevity as the sole outcome indicator was refined into a more discriminating instrument assessing the quality of the years of life added by treatment. Thus to a refined probability of outcome and cost-benefit ratio was added the third dimension that gives the instrument its name. One year of current life in good health is counted as one QALY, and one year of current life with a lower level of health q ($q < 1$) is counted a q QALY. The system allows a health profile over expected life to be calculated as the probability of a numerical gradient for quality of the life that a given treatment would extend. In this way an instrument originally designed to enhance efficiency became an instrument for assessing relative benefits to patients and assigning treatment regimes a priority. It became, in other words, a tool for rationing medicine.

The strength of QALY is its power to describe the distribution of treatment costs relative to outcomes in a given system, and its capacity to identify the likely treatment outcomes for a given patient. This information assists the doctor to decide when to abstain from procedures unlikely to yield any healing or palliative effect, or to abstain from treatments whose likely benefits are not proportional to the costs.

Of the numerous objections to the implied ethics of the QALY I shall discuss two.

It has been noted that QALY trades off the lesser benefits to one patient against the greater benefit to another. This is inherent in any cost-benefit approach to resource allocation, but it is contrary to declared international and Australian norms, which direct care toward the patient irrespective of other patients. Thus the Australian Medical Association *Declaration of Cooperation* with the Commonwealth National Health Strategy states that

All Australians must have optimal access to health care . . . the well-being of the patient must be central to all policies. This must over-ride any considerations of bureaucratic convenience . . . the highest standard of patient care, commensurate with resources available, requires regular and genuine consultation with professional clinicians . . .

However, the AMA and the Commonwealth government are aware that only a portion of Australians have optimal access to health care; that chronic care, rehabilitation, and other categories of care are markedly under-resourced while some services are

generously resourced; and finally that there is no prospect that all Australians will have equal access to optimal care. To continue to proclaim this ideal risks entrenching a hypocrisy that provokes the anger of client groups.

It is more truthful and possibly better politics to acknowledge that care is scarce relative to demand and that consequently patient claims to care are in competition with one another. In this matter I differ from Nick Tonti-Filippini, who states that “rationing . . . cannot help but produce grave injustice at the clinical level. Illness is not measurable in economic terms.”³

Yet Tonti-Filippini states in the same essay that

Expressions of anger and frustration toward government and bureaucracy are the norm in our hospitals, and the public is losing confidence in a health system which cannot deliver the reassurance that care is available to all the sick. . . . the so-called “health system” is no system at all but a conglomeration of interests [competing for budget shares].⁴

Here it is admitted that illness after all has a dollar measure; that inequities exist; and that the public, tutored by government and health providers to expect optimal service, are angry about the shortfall. These are the structural features with which any allocation ethics must deal. The welfare state in its heyday did not eliminate them, and in its decline there is no probability that equality will be achieved.

In these circumstances funding authorities must decide what are the priority areas. If they are to be, for example, primary, chronic, and palliative care, attention will need to be given to the terms on which costly acute care programmes are continued. Criteria of patient selection, already operative for transplantation services, must be refined and for this purpose the QALY instrument is serviceable.

The second objection to QALY is one that I share. It is that the quality of life index q is a specious number. It purports to be objective in the sense that it calculates the values that a sample of patients, care-givers, and immediate family assign to health statuses. The judgments are averaged to obtain the value of living with different degrees of comfort, pain and disability.

But the value assigned to q will depend on how the sample is determined. If it is composed of the parents and immediate family of a seriously disabled child, q will be high. If the sample is expanded to include spouses who elected to terminate a handicapped fetus, the q value will diminish. Inclusion of medical staff will diminish q further while the inclusion of irritated tax payers and chronic care patients will lower q yet again. Clearly the sample can be manipulated to obtain any q value one pleases. If q were an objective value, QALY's originators would assuredly merit a Nobel peace prize.

A noteworthy feature of QALY is that it weights pain negatively, as if a life of pain weren't worth living. One is surprised that a profession that deals every day with chronic pain should not have challenged this bias. Many chronic pains are untreatable. Many surgical and injury pains are untreatable. Pain clinics, not to mention biographies and memoirs, are stocked with histories of tormented lives that were nonetheless creative and abundant in giving. Other histories—histories of inhumanity—tell of millions subjected to unspeakable insults to the soul and torture of the body. Reading the narratives we wonder why they wished to endure for a day. Those who returned from these contrived hells say that the will to live was steadfast, and that mere survival was a badge of victory over brutality.

Further lessons lie in the extraordinary idea that pain is a stigma. Medical training indirectly endorses this curiosity in teaching that the appropriate response to complaints of pain is to relieve the symptoms and to remove the cause if possible. In the neighborhood surgery this usually translates into scripts for analgesics. One side-effect is 8000 prescription drug-dependent Australians, most of them women and teenagers. Another side-effect is that the lore on how to live with pain, based on millennia of human experience, is brushed aside even though pain clinics validate at least part of the lore, for example, the fact that placebos give some pain relief for about 30 percent of complaints. Contemporary medicine strips pain of its moral qualities to interpret it as a dysfunction from which the patient has a right to relief. Meanwhile the basic zoological fact that pain is ingredient to life is forgotten in the course of promoting the fantasy of a painless existence; this in turn drives escalating demands for medical care.

Ponder the irony. Although there is probably no greater source of inflicted suffering than therapeutics and diagnostics, medicine, to the applause of utilitarians, denies the

personal and ethical value of pain and pain tolerance. In that way medicine contributes to the anxiety about suffering manifest in the clamour for ever more health care and to the consumer movement for a pleasant death.

Might the health care crisis be due in part to induced mass anxiety about pain and sickness? Have we medicalised sickness, pain, and death to the point of neurosis?

That we may have become sick of sickness is suggested by the increasing acceptability of a solution to the glut of sick people: let them be selectively killed—painlessly of course. However, killing is homicide and this creates a difficulty. There is a way around it. As the abortion experience shows, judges in applying the law of homicide to clinics follow considered medical opinion; change medical opinion and you have changed the law. Thus it is proposed that the physicians' last duty to patients is to prevent unnecessary suffering by terminating life deemed to be irreversibly beneath what healthy persons regard as unacceptably low quality. It is claimed that there is a right to a painless death and consequently that law must permit it.

But this is still small beer. The threshold to something really big is the conviction that there is "life unworthy of life". On the yonder side of this threshold roams the bioethical culling team pondering which categories of patient are to be deemed no better than vegetables and denied the enabling label, "person". This is no longer the right to die at a time of one's choice. It is mock triage of large patient populations to prepare clinical staff mentally to administer death according to schedules of eligibility. The cultivation of this conceptual killing field for several decades has made it so familiar that one is no longer startled by books bearing the titles: *Who Lives? Who Dies?*, *Causing Death and Saving Lives*, *What Kind of People Should There Be?*.

Bioethicists have proposed various criteria for personhood and still more applications to particular cases. Thus we learn that the senile, the irretrievably comatose, and the three month infant are not persons, while chimpanzees, livestock, and extra-terrestrials are. Let me quote to you an example of this sublime rationality: "On any fair comparison of morally relevant characteristics, like rationality, self-consciousness, awareness, autonomy, pleasure and pain, and so on, the calf, the pig and the much derided chicken come out well ahead of the fetus at any stage of pregnancy—while if we make the comparison with a fetus of less than three months, a fish, or even a prawn would show more signs of consciousness."⁵ There you have it: the autonomous

porker, the self-conscious heffer, and the rational rooster, dogmatically asserted without reference to evidence about the consciousness of these creatures and without intimate experience of them. Autonomy is ascribed to them but we are not told what are their duties to one another and to our species nor how the brutes learn their duties. But such questions are beside the point. Animal liberation is the moral fashion of bored urbanites who know animals only as pets and who experience nature as casual visitors to rain forests. They bless the peacefulness of the forest unaware of the predation and parasitism inherent in its ecosystem and uncurious about the behaviour of its denizens. If by some mad chance they obtained their wish and livestock were liberated, those animals would quickly perish because they are adapted to domestic conditions. So much for benevolent intentions toward animals. What about our kind? The point of the comparison before us is to raise livestock above the value of the creature that pregnant couples call their child. It is here, in this simple, spontaneous cherishing of the unborn child, that the essential value conflict is joined. The ethicist lavishes compassion on mullets and chooks, and protests the "atrocities" perpetrated on them. But he finds no value in the unborn life that the mother calls her child. Thus the ethicist is estranged from a fundamental human experience of life's value, just as he is blind to the "atrocities" that animals perpetuate on one another by the conditions of their existence. Should medical ethics come to deny *this* value, and get away with it, the road is clear to deny value to any category of patients.

Estranged from experience by abstraction, certain philosophers spread confusion about personhood. Although philosophy has been cultivated for 2500 years, it has arrived at no stable method of inquiry and no certain identification of its subject matter. Among my generation, the sense of failure hovered like a raven over our studies. The universality of Reason and the rigor of Logic, vouchsafed by our teachers as emblems of integrity, were mocked by the spectacle of philosophy departments split into quarrelling factions. Our teachers pronounced sweeping judgments on human traits, as is exemplified in the previous quotation, without feeling any obligation to square them with the findings of the empirical sciences; these were dismissed as "mere facts." So it is not surprising that personhood is an unstable concept in this literature. Sometimes it is used as a defining trait that a thing either has or doesn't have. Sometimes it is treated as a scale on which animals and humans, or perhaps also plants and extra-terrestrials, can be arranged according to their degree of consciousness. But I find no instance in which these thinkers ponder what kind of persons *they* are in laying down prescriptions about who is to live and who is to die.

They are, I fear, rather too stuck in the conceit of their own goodness for such a question to be taken up in earnest. We are obliged then to do it for them.

The results of the ethical training in mock killing are now coming in. There are signs that a killing frenzy has been unleashed. Derek Humphrey's best-seller, *Final Exit*, contains detailed advice on the acquisition, storage, and use of 16 lethal doses; he explains the use of other devices, such as a plastic bag, to assure that the suicide attempt will succeed. While he warns away all readers who do not "rationally" consider "self-deliverance", this is unlikely to deter vulnerable groups, such as youth, whose suicide rate has soared in recent years. He doesn't consider at all that suicide recipes can be used equally well for homicide. He praises the German euthanasiasts' preferred agent of death, cyanide, even while acknowledging its previous "misuse" to destroy millions.

The word "deliverance" has a history in the euthanasia movement. In his study of the euthanasia cinema,⁶ Ludwig Rost draws attention to a film in which the protagonist is shown saying to the corpse of a pet that she has put down, "So now you are delivered from your pain." In another scene someone tells a friend of "delivering" his faithful old dog. When the friend expresses surprise at the word, the protagonist earnestly repeats it: "Yes, deliverance." The film then transfers the sentiment of lethal compassion to human beings. The protagonist Hanna falls ill and pleads with her morally frail husband: "You must help me remain your Hanna to the end, and not become something else—deaf, blind, idiotic. I couldn't endure that." Hanna eventually requests deliverance. The husband refuses, but a morally robust friend comes to her rescue.

Since these sentiments match contemporary euthanasia sentiments, it is instructive to note that the film, entitled *I Accuse*, was made and distributed in Nazi Germany just as the euthanasia programme began in secret. It was followed two years later by *Existence without Life*, in which lethal compassion was replaced by lethal indignation against many categories of the chronically ill or disabled, who are abused as "useless eaters" and "life unworthy of life". Today's equivalents are "staying at the table when the meal is over," "past their shelf life," "hopeless case," and "nothing but a vegetable".

The continuity between an earlier phase of medical killing and current practice is also

affirmed in the recent revival of the phrase, “life unworthy of life”. The phrase was coined in 1922 by a psychiatrist and jurist in a tract advocating the incorporation of the killing function into medicine. It was taken over by the Nazi government to indicate the orientation of its zealous extinction of the unfit. Despite the notoriety that this use occasioned, the phrase and the concept have been recently reaffirmed in the most provocative manner possible—in the midst of the impassioned euthanasia controversy in Germany. We are apprised that “every rational and compassionate observer must admit that there is life unworthy of life.”⁷

Let us take thought. This statement endorses the utilitarian concept that provided the ethical ground for the Nazi doctors’ euthanasia program. Repudiation of that ethical ground as inhumanity was the starting point for post-war medical ethics. And now, just a half century after anathema was pronounced on that inhumanity, its principle is reasserted very publicly in Germany by one of Jewish heritage.

Let us take thought again. Every rational and compassionate observer must admit that there is life unworthy of life. This is the ethical core of lethal compassion, not the appeal to autonomy that would justify voluntary euthanasia. Life unworthy of life usually does not leave the table when the meal is over; it must be pushed away. Since there are many categories of unworthy life, and many millions in these categories, killing on the scale of genocide is indicated. When the scale is recognized, compassion transforms itself into a resolute will. The idea dawns that the Nazi doctors were right after all.

Let us take thought yet again. Every rational and compassionate observer This is a persuasive appeal. Inexperienced students who wish to be thought rational and compassionate by their mentors are likely to respond to it. But the Teacher’s golden words seem to have overlooked something. Why only rational and compassionate? May not irrational humans and liberated animals perceive some life to be unworthy of life? And why restrict this perception to the compassionate? May not the brutish and malevolent share it? Ladies and gentlemen, every educated person outside the philosophy department knows that the chief exponents of this credo have been the criminal, the persecuting zealots, the enraged, the barbarians, and the psychopaths. This ordinary criminal maxim is now to be brought into the clinic as refined ethical conduct.

I fancy someone may say: “It is a stirring speech, but it seeks to incite alarm where none is warranted. Our clinical services are basically sound. There is no cause for alarm.” Consider then the case of Dr Jack Kevorkian, the inventor of the infallible suicide machine. Dr. Kevorkian was recently indicted for the murder of Susan Williams. At his trial for the death of Janet Adkins, the prosecution established that he did not medically examine her, nor another woman who, rescued from his attention, was found to be suffering from treatable migraines. In an assessment of Kevorkian written two years ago, bioethicist Colleen Clements noted that he made contact with Adkins through advertisements for persons willing to be experimental subjects for his machine. She believed that he had an eroticized obsession with death. This opinion was resented by her colleagues at the University of Rochester Medical School, who had only praise for Kevorkian’s “courage”. It disturbed Clements that qualified psychiatrists could not recognize the man’s sickness; it meant that they were even less able to recognize the aggression in their own enthusiasm for euthanasia. In a sardonic mood she wrote that medical ethics had been so transformed that “it becomes hard to tell a physician from a mortician.”⁸

Kevorkian’s indictment vindicates her insight and furnishes an important lesson. The case shows that medically qualified persons sincerely persuaded of the ethical reality of mercy killing nonetheless failed to detect the pathology of a serial killer masquerading as benevolence, even though he paraded his illness on the national stage. The case suggests that impaired physicians acting without fanfare in the clinic are unlikely to be distinguished from those who act from benevolence. Is this not cause for alarm?

That pathology, especially anxiety, depression, and other syndromes drive the euthanasia movement is apparent in its morbid ideation. Consider this passage by Daniel Meynen, writing for the German Society for Humane Death:

The duty to suicide occurs when through my continued living lack of autonomy, misery, isolation, uniformity, unfruitfulness, incurability, lameness, pain, insensitivity, disgrace, madness, and sin threaten to become the norm for humanity and my suicide is the only means available to me to prevent this.⁹

Here is sickness writ large. The guilt and worthlessness expressed in this passage are readily recognised as the ideation of sickness depression. Many patients who said, “Doctor, let me die” have been returned to health by caregivers who ignored the

request. The euthanasia movement death wish is distinctive for the linkage made between the individual sickness depression and the dignity of humanity. The link is provided by the belief that humankind is the ethical peak of all existence, because there is no God and no Redeemer. However, “sickness unto death” is a profound blemish on the humanist world. The alternative to eliminating death is to tame it, to humanise it, by making it an act of will. For the humanist, life as such is of no value. Human will alone is sacred.

The sanctity of the will is enshrined in bioethics as the doctrine of the moral primacy of personal autonomy, which is in turn the basis of the concept of personhood just discussed. The fountainhead of this doctrine is J.S. Mill’s *On Liberty*. There we find a hurricane of petulance beating against the “despotism of custom” or again the “tyranny of the majority” because, to his mind, human experience entrenched as custom is “the standing hindrance to human development”. Mill’s alternative was the notion that each individual should develop the genius within by pursuing her or his own good in her own way. Addressing tyrannous society, he grandiloquently expostulated, “I denounce and reprobate this pretension [of deciding for others what is to their good].” He despised and feared the great mass of human beings whom he doubted would adopt his ethics; so he denigrated them as little better than brutes who have “no need of any other faculty than the ape-like one of imitation . . .” But to the “instructed classes” he gave the foundation of a new ethics; it is the dictum that “all restraint, qua restraint, is evil.”¹⁰ On this showing, there are no duties; the moral universe has been pulled inside out so that its centre is ME. But to appreciate fully Mill’s doctrine, we need to recall that he identifies the good with pleasure and evil with pain. This is Hedonism. Mill knew well that Hedonism had never been a public ethic in any civilisation and that in Western culture it had lost out to Christianity and the Stoic ethic. Bentham had already modified Hedonism by calling it Utilitarianism. Mill went a step further by appropriating from Stoic ethics the concept of the autonomous moral agent. The result was the notion of a hedonist or voluptuary as a free moral agent. I will not enter here on the exoticism of this concept, which defines moral agency in terms of a narcissism toward suffering (including animal suffering). Suffice it that Mill’s petulance outfits the suffering self with rights to pleasure and to pain avoidance. The concentration of such rights in the individual constitute what I call Mill’s Doctrine of the Sanctity of the Will.

Contemporary utilitarians making a new experiment in living identify the customary

inhibition on killing as a restraint upon their autonomy. It is obnoxious; painful. They seek to vindicate the sanctity of the will against legal and customary restraints on killing. They also seek to enjoy the pleasures of killing regardless of public acceptance, but this must be done stealthily.

The need to conceal certain kinds of pleasures has long been recognized by utilitarians. In his *Method of Ethics*, published in 1874, Henry Sidgwick noted that certain acts that are contrary to public belief may be pleasant and right in themselves but wrong if they were known, since, among other contingencies, law officers may prosecute. He recommended stealth as the means to reconcile the situation. Looking to the general case, he stated that “the opinion that secrecy may render an action right which would not otherwise be so should itself be kept comparatively secret; and similarly it seems expedient that the doctrine that esoteric morality is expedient should itself be kept esoteric.”¹¹

From such principles there has developed a perfidious utilitarian morality that may be called “Machiavellianism in the clinic.” Its common name is Situation Ethics, a doctrine propounded three decades ago by the theologian widely regarded as the father of bioethics, Joseph Fletcher. In a recent review of Fletcher’s thought published in the authoritative *Journal of the American Medical Association*, the reviewer drew attention to Fletcher’s dictum that we should do no harm “except when the end justifies the means.”¹² This authority expressed no objection to Machiavellian’s cardinal maxim as a rule of medical ethics.

Or again, consider the statements of a prominent utilitarian in a lecture to the Harvard University Inter-Faculty Program on Bioethics. The topic was Lying in the Professions. The speaker introduced his remarks by saying that he was speaking that day as a consequentialist utilitarian, although in his published writings on euthanasia he defends preference utilitarianism, which disallows involuntary euthanasia. In the course of his remarks he stated that “as euthanasia becomes more accepted, it can be used to get rid of morally undesirable people.” He added that he would not want that view to be repeated “outside this room.” I was not surprised at this suggestion. Consequentialist utilitarianism has no need of tortured distinctions between persons and non-persons to justify killing. It can be directly justified on the grounds that particular killings promote the general welfare, as indeed every terrorist and conqueror has believed. What did surprise me was that the legal or medical experts in the

audience raised no objection to the speaker's matter of fact recommendation of betrayal of medical trust and reintroduction of the death penalty as secret medical assassination. Their approval by silence indicated that esoteric utilitarianism is acceptable among these expert cadres.

Esoteric utilitarianism grounds in the sanctity of the will and its talisman that all pain and restraint are evil, which, as we saw, is readily converted to the central belief of the spoiled child. Its rarified, philosophical expression is the dictum that the autonomous will is its own law, since human goodness is willing one's will.

Since utilitarians like to position themselves at the cutting edge of humankind's moral development, it may be surprising that their doctrine is captured by that dictum of a thoroughly spoiled generation of youth: If it feels good, do it! However, philosophers tend to be humanly inexperienced and therefore don't know that the emanations of rarified intellect often repeat a fixed pattern of thought. The spoiled brat philosophy is among the oldest enthusiasms of clever jakes. A renaissance version of it reads: "To the righteous man no law is given; only be pious, and for the rest, practise what thou wilt; yield to thine own caprice and passion, and if thereby others suffer wrong, commend them to the consolations and hopes of religion, or better still, call them irreligious and condemn them to perdition." Plato knew this cleverness well; he represents it as the secret belief of aspiring tyrants. Freedom from religious law was the highest level of enlightenment among the Assassins cult in medieval Syria. In medieval Europe, personal autonomy was the doctrine of a succession of heresies, among them the Apostolici, the Waldensians, the Luciferians, and the Antinomians. Later the doctrine circulated among Rosicrucians, Freemasons and even some Jesuits. It was incorporated into the seventeenth century political doctrine of monarchy, where the will of the sovereign is absolute. According to Feodor Dostoevski, it was the doctrine of Nihilists. Today it is the doctrine of terrorists and of organised crime. Intellectually speaking, the doctrine is a cliché despite its appeal to virile assertiveness.

Thus the theory of esoteric utilitarianism. What of the practice? The current trial with euthanasia in the Netherlands tests the assurance that the removal of restraint on the will to medical killing will not lead to abuse.

The official *Dutch Euthanasia Survey Report*¹³, published last year, indicates that the good will to killing has set to its benevolent work with gusto. The over-all figure is

25,306 physician-assisted deaths in 1989-1991. That is a staggering 20 percent of the total deaths. The break-down is:

2,300 deaths on request

400 assisted suicides

1,000 lethal injections without explicit request

4,756 deaths after request for non-treatment

8,750 deaths in which treatment was withdrawn or withheld without the request of the patient with the intention of killing

In his evaluation of the *Report*, John Keown, Director of the Leicester University Centre for Health Care Law, stated that “the vast majority of deaths from euthanasia are illegally and incorrectly reported as natural deaths, [which] itself casts doubt on the lawfulness of much of the euthanasia which is being carried out.”¹⁴

This should come as no surprise. The prediction that tolerance of euthanasia would be abused is based on considerable evidence—some of it surveys carried out by euthanasia advocates—showing that 20-30 percent of responding doctors (or 10-15 percent of the sample) acknowledge secretly killing some patients even though this act is homicide. As happened with abortion, some doctors disregard the law because privately they say that “the law is an ass.”¹⁵ Why indeed should autonomous doctors respect mere law, based as it is on an ethical vision that denies the sanctity of the will?

In his digest of the Dutch Report, John Fleming writes: “The right to life cannot be given up without threatening the right to life of other members of the community. When medical killing is allowed in some circumstances, the number of circumstances in which such killings occur quickly increase.”¹⁶ To assess the extent of the likely killing when sanctions against euthanasia are removed, we need a clear view of collateral influences. One of these is the anxiety about over-population.

This spectre has been with us since Malthus raised it in 1798. Two decades ago it went to international agendas under the slogan “zero population growth”; today it is integral to the charismatic environmentalist movement, whose compassion for man-

damaged nature often translates into the ascription of rights to animals and malice toward human beings. Traces of this attitude are found among sober and responsible authorities. The Challis Professor of Anatomy at the University of Sydney is exemplary. After a careful review of population growth and its relation to environmental carrying capacity, Professor Jonathan Stone stated: “We are threatened by the realisation that these many problems are but symptoms of an underlying cause, and the cause is a plague and the plague is us.”¹⁷ This he dubs “the people plague.” He notes that the simultaneous decline of fertility to below replacement value in Europe and elsewhere signifies a “subliminal recognition” that there are too many people, that the Boat is Full. One result is 30 million aborted births annually world-wide, as estimated by the World Health Organisation, which vigorously supports population control as fundamental to a sustainable future. Here medical killing has been promoted from a women’s right to control her reproduction to a collective moral duty to *prevent* reproduction, as is starkly shown in the Peoples’ Republic of China.¹⁸

When these and other collateral influences are borne in mind, the question is not whether this or that set of guidelines for assisted death provide adequate safeguards, but whether the inviolability of life asserted in welfare state guarantees of human rights and human dignity can withstand the strong impulses driving acceptance of medical killing as a means of reducing the people plague and of obtaining relief for stressed health budgets. Let us recall the pressure points:

- Medical killing is now a consumer item strongly promoted by the media and by many in the health field;
- The clientele for this item is large because the mass administration of analgesics has eroded the personal religious discipline for living with bleakness, pain, and death;
- Competition for scarce resources among patient groups and within health services even now exerts pressure to reduce patient populations; the pressure will increase as the public become aware that a large proportion of the health budget is expended on the last eighteen months of life;
- The acceptance of abortion has established for many the legitimacy of medical killing to control populations;

- Permissiveness toward medical killing helps resolve the intractable problem that the welfare state's commitment health care entitlements for all is financially insupportable.

What lessons for allocation equity can be drawn from these reflections? In a long period of retrenchment now upon us, the horizon of expectations will scale down. In the short-term this is likely to intensify competition for scarce resources. However, public consultation on allocation equity may help the public to appreciate what harassed governments already know—that any conceivable equity formula will be perceived to be unfair by significant sections of the public. Certain loci of contestation have been identified as probable structural features of future allocation equity; among these the competition between generations—the young vs. the aging—will be the most severe. Since aging is a natural process irreversible by policy, neither draconian social change nor esoteric morality can provide a remedy. When the limit of solutions is reached, so is the limit of the will; the “problem” then becomes a signature of the human predicament.

To live and to live well with the human predicament is what must be relearned. Our culture of emancipated desire chafes at predicaments even though no generation has ever escaped them.

The predicament of everyone is mortality. Medical experience has long since learned how to deal with it: to heal where possible, to comfort always, and to provide those small but humanly significant mercies of restoring confidence, courage and hope. This obvious wisdom has been obscured by the development of high technology medicine and the interposition of welfare state administration at the bedside. The chairman of this evening's meeting recently wrote on this topic and I should like to conclude by commending to you his thought.

As a minister in two governments that installed the apparatus and rationale of the welfare state, he recalled what was the thinking of those who installed it. Australian society seemed stable and unchanging. Family ties and tribal loyalties bonded communities in caring for one another in a difficult and sometimes perilous life where choices were few and usually clear. Medicine lacked most of its contemporary sophistication. But the trust between doctor and patient was strong, since they were

neighbors and one another's keepers. The patient was viewed as a whole individual, not as a body afflicted by a disease entity. The medical art consisted above all in "the primary healing art of listening, counseling, rebuilding human dignity and self-esteem, showing compassion and understanding."¹⁹

That was the medicine of yesterday. Can this healing art be recovered in today's hi-tech, anonymous hospital environment? Sir John conjured the even greater hyper-complexity of tomorrow's hospital setting, and abstained from forecasts, for who can predict where an unprecedented involuntary experiment in living through technology is underway. But he did not hesitate about values. Regardless of the environment, humankind remains the same, he said. What we need in illness and death is ministrations to perplexity, to anxiety and fear, and uplifting of the human spirit.

The poet has said that the mark of wisdom is to see the miraculous in the common. Sir John has helped us understand that these small mercies are in the end are what medicine is about.

Appendix A

Autonomy in Medical Science

From time to time scientists document, in autobiographical and other statements, their actual feelings about the powers of modern technology and about themselves as discoverers and disposers of those powers. The discovery of recombinant DNA prompted many such statements from molecular biologists in the Sixties. Public disquiet about what the “gene doctors” were up to, and action by public authorities to set limits to experimentation, turned the assertive tone down. The statement below, by Robert H. Moser in 1983, revitalizes for science the Promethean spirit that previously scandalized the public. The reader will note the frank criminality of this credo.

“The intellectual imperative is the unquenchable spirit and relentless desire to explore and expand knowledge to the ultimate, to invent the uninvented, to discover the undiscovered, to create the uncreated. And the devil take the consequences. No power on earth can stop the mind of man. . . . the single-minded dedication to pursuit of truth most often casts aside or ignores all external considerations . . . the scientist hot on the trail of new knowledge . . . is not inclined to reckon with the social or political or economic implications of his potential discovery. . . . the Manhattan Project was accelerated by momentous historical events, but many scientists were fascinated by the chase, *per se*. For them the potential for a nuclear Armageddon was thrust aside as a momentary dark reflection. . . . In similar vein, a like phenomenon is occurring in genetic engineering. The scientists who entered the fearsome lists of hybrid creativity paused only momentarily to reflect on the social, moral, and political implications. Then they . . . plunged ahead in their relentless pursuit of new biologic forms. Now the research is continuing with unprecedented rapidity. Efforts are abroad to sever all regulatory restraints. A few nervous religious ethicists continue to scratch their heads in concern, but . . . I suspect that even if those anxious individuals . . . had ever joined forces to create laws to inhibit genetic engineering, the intellectual imperative would have prevailed; the laws would have been circumvented or violated, and the

research would have continued. . . . We can tether the giant of technology, . . . but we will never stop the inspired investigator . . . He will defy politics and economics and threats of physical harm. He will work in basements and garrets. He will plead for or purloin equipment to pursue his star to others he whispers: “We have no time for your puny politics or social concerns”

Robert H. Moser, M.D., *The Intellectual Imperative and the New Technology*, in *The Technology Explosion in Medical Science*, ed. James R. Gay and Barbara J. Sax Jacobs, New York: SP Medical and Scientific Books, 1983, pp. 17-19.

¹Portions of this lecture were published as The resource allocation dilemma, in *Healthcare* 2 (1992), 40-42, 45-46.

²See Bert Spilker, ed., *Quality of Life Assessments in Clinical Trials*, New York: Raven Press, 1990; S. R. Walker and R. M. Rosser, eds., *Quality of Life: Assessment and Application*, Lancaster: MTP Press, 1988.; G. T. Smith, ed., *Measuring Health: A Practical Approach*, New York: Wiley, 1988; and John La Puma and Edward F. Lawlor, Quality-Adjusted Life-Years: Ethical Implications for Physicians and Policymakers, *Journal of the American Medical Association* 263 (1990): 2917-21.

³Nick Tonti-Filippini, Ethics and the Allocation of Scarce Health Resources, in *Ethics and Resource Allocation in Health Care*, ed. Bernard Clarke and Mary Stainsby, Melbourne: St. Vincent’s Bioethics Centre, 1991, p. 129.

⁴*Op. cit.*, p. 127.

⁵Peter Singer, *Practical Ethics*, Oxford: Oxford University Press, 1984, p. 118.

⁶Ludwig Rost, in *Thema: Erinnern: Medizin und Massenvernichtung*, ed. T. Bastian and K. Bonhoeffer, Stuttgart: S. Hirzel, in press.

⁷Special issue of *Analyse & Kritik: Zeitschrift für Sozialwissenschaften*, December 1990, p. 125.

⁸Personal communication, June 25, 1990.

⁹*Zur ethischen Beurteilung der Selbsttötung*, Deutsche Gesellschaft für humanes Sterben, 1982.

¹⁰J. S. Mill, *On Liberty*, Indianapolis: Bobbs-Merrill, 1956, p 116.

¹¹Henry Sidgwick, *The Method of Ethics*, 7th ed., London 1907, p. 382

¹²George J. Annas, *Journal of the American Medical Association* 261 (1989), 454.

¹³Known as the *Rimmelick Report*, The Hague, 1991. See Paul J. van der Mass, *et al.*, Euthanasia and other medical decisions concerning the end of life, *Lancet* 333: 8768 (1991), 669.

¹⁴John Keowan and I.J. Keown, The law and practice of euthanasia in the Netherlands, *The Law Quarterly Review* 108 (1992), 7-8.

¹⁵Bioethicists openly disparage the law. After quoting the Federal Republic of Germany constitutional law on the inviolability of human dignity, Helga Kuhse styled it an “empty formula” that provides no answer as to whether “it is ethically required to maintain the lives of patients by all means . . .” Helga Kuhse, *Menschliches Leben und sein Würde. Fragen des Lebens und des Sterbens*, Forschungsberichte 19, Forschungsinstitut Philosophie/Technik/Wirtschaft, University of Salzburg, 1990, p.10.

¹⁶John I. Fleming, *Euthanasia, The Netherlands, and Slippery Slopes*, Occasional Paper, Adelaide: The Southern Cross Bioethics Institute, 1992.

¹⁷Jonathan Stone, *Environment, Plague and the Problem of Charity*, Australian Foundation for Science Lecture, ANZAAS, Oct 1, 1991. Mimeo.

¹⁸A cameo of this predicament is the dispute about whether China's population control program is in fact coercive. If it is, then the Australian government is obliged, by its human rights commitments, to protest it. The government sought advice from a AIDAB demographer, who advised that although coercion sometimes occurred, it was contrary to the Chinese policy. This Report (*Recent Population Policy in China*) was rebutted by another Report tabled in the Senate. See John S. Aird, *Foreign Assistance to Coercive Family Planning in China*, Australian Senate.

¹⁹Sir John Carrick, The past, present and future of medicine, *Medical Journal of Australia* 155 (1991), 731-732.