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Voluntary Euthanasia Debate is Volume 359 in the ‘Issues in Society’ series of educational resource books. The aim of this series is to offer current, diverse information about important issues in our world, from an Australian perspective.

KEY ISSUES IN THIS TOPIC
Euthanasia has been illegal in Australia since the federal government overturned short-lived Northern Territory laws in 1996. Despite it being a crime to assist in euthanasia, prosecutions have been rare. Four decades’ worth of opinion polls have shown that a majority of Australians appear to support the legal option of aid-in-dying for those suffering intolerably and without relief near the end of life.

Although a significant number of countries and US states have legalised euthanasia and assisted suicide in recent years, Australian federal and state governments have continued to debate the political, legal and ethical implications of legalised voluntary euthanasia.

What are the many ethical, religious and practical arguments asserted by those who champion the ‘right to life’ as opposed to those who assert the ‘right to choose’ when and how to die? Can palliative care always provide adequate pain relief? If legalised, could voluntary euthanasia be the ‘slippery slope’ that leads to involuntary or non-voluntary euthanasia? Is voluntary euthanasia dignity in dying, assisted suicide, or homicide?

This book presents a range of considered opinions from Australia’s medical profession and opposing pro-life and pro-euthanasia lobby groups.

SOURCES OF INFORMATION
Titles in the ‘Issues in Society’ series are individual resource books which provide an overview on a specific subject comprised of facts and opinions.

The information in this resource book is not from any single author, publication or organisation. The unique value of the ‘Issues in Society’ series lies in its diversity of content and perspectives.

The content comes from a wide variety of sources and includes:

➤ Newspaper reports and opinion pieces
➤ Website fact sheets
➤ Magazine and journal articles
➤ Statistics and surveys
➤ Government reports
➤ Literature from special interest groups

CRITICAL EVALUATION
As the information reproduced in this book is from a number of different sources, readers should always be aware of the origin of the text and whether or not the source is likely to be expressing a particular bias or agenda.

It is hoped that, as you read about the many aspects of the issues explored in this book, you will critically evaluate the information presented. In some cases, it is important that you decide whether you are being presented with facts or opinions. Does the writer give a biased or an unbiased report? If an opinion is being expressed, do you agree with the writer?

EXPLORING ISSUES
The ‘Exploring issues’ section at the back of this book features a range of ready-to-use worksheets relating to the articles and issues raised in this book. The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

FURTHER RESEARCH
This title offers a useful starting point for those who need convenient access to information about the issues involved. However, it is only a starting point. The ‘Web links’ section at the back of this book contains a list of useful websites which you can access for more reading on the topic.
EUTHANASIA IN AUSTRALIA

Euthanasia is illegal in Australia, but was legal for a period in the Northern Territory, according to the following overview from Wikipedia

Current situation

Although it is a crime to assist in euthanasia, prosecutions have been rare. In 2002, relatives and friends who provided moral support to an elderly woman who committed suicide were extensively investigated by police, but no charges were laid. The Commonwealth government subsequently tried to hinder euthanasia with the passage of the Criminal Code Amendment (Suicide Related Materials Offences) Bill of 2004.

In 2008 Shirley Justins and Caren Jennings, were found guilty of manslaughter and accessory to manslaughter respectively for providing Nembutal to former pilot Graeme Wylie in 2006. Justins claims that Wylie wanted to die “with dignity”. The prosecution argued that Graeme Wylie did not have the mental capacity to make the crucial decision to end his life, classing it as involuntary euthanasia.4

In August 2009, the Supreme Court of Western Australia ruled that it was up to Christian Rossiter, a 49 year old quadriplegic, to decide if he was to continue to receive medical care (tube feeding) and that his carers had to abide by his

WHAT IS EUTHANASIA?

Euthanasia derives from the Greek for ‘eu’ (easy, good) and ‘thanatos’ (death) and refers to the practice of intentionally ending a life in order to relieve pain and suffering.

There are different euthanasia laws in each country. The British House of Lords Select Committee on Medical Ethics defines euthanasia as “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering”. In the Netherlands, euthanasia is understood as “termination of life by a doctor at the request of a patient”. Euthanasia is categorised in different ways, which include voluntary, non-voluntary, or involuntary. Voluntary euthanasia is legal in some countries and US states. Non-voluntary euthanasia is illegal in all countries. Involuntary euthanasia is usually considered murder.

wishes. Chief Justice Wayne Martin also stipulated that his carers, Brightwater Care, would not be held criminally responsible for following his instructions. Rossiter died on 21 September 2009 following a chest infection.5

Exit International made TV ads arguing for voluntary euthanasia, which were banned just before they were scheduled to broadcast in September 2010.6

Legalisation in the Northern Territory

Euthanasia was legalised in Australia’s Northern Territory, by the Rights of the Terminally Ill Act 1995. Soon after, the law was voided by an amendment by the Commonwealth to the Northern Territory (Self-Government) Act 1978.

The powers of the Northern Territory legislature, unlike those of the State legislatures, are not guaranteed by the Australian constitution. However, before the Commonwealth government made this amendment, three people had already died through physician-assisted suicide under the legislation, aided by Dr Philip Nitschke. The first person was a carpenter, Bob Dent, who died on 22 September 1996.

Organisations

The euthanasia advocacy group YourLastRight.com7 is the peak body nationally representing the ‘Dying with Dignity’ associations of Queensland, New South Wales, Victoria and Tasmania8, as well as the South Australian Voluntary Euthanasia Society (SAVES)9, the Western Australian Voluntary Euthanasia Society (WAVES)10 and the Northern Territory Voluntary Euthanasia Society (NTVES)11.

TV ads arguing for voluntary euthanasia, were banned just before they were scheduled to broadcast in September 2010.

Exit International is a euthanasia advocacy group founded by Philip Nitschke in Australia. Other Australian groups include Christians Supporting Choice for Voluntary Euthanasia12 and Doctors for Voluntary Euthanasia Choice.13

References

7. www.yourlastright.com.au
9. www.saves.asn.au
10. www.waves.org.au
11. www.ntves.org.au
12. www.christiansforve.org.au

Source: Wikipedia, the free encyclopedia
Last modified 11 December 2012
Euthanasia in Australia | http://en.wikipedia.org/wiki/Euthanasia_in_Australia
Legality of euthanasia around the world

A GLOBAL OVERVIEW FROM ONLINE ENCYCLOPEDIA WIKIPEDIA

Efforts to change government policies on euthanasia in the 20th century have met limited success in Western countries. Euthanasia policies have also been developed by a variety of NGOs, most notably medical associations and advocacy organisations. As of 2011, active euthanasia is only legal in the three Benelux countries: the Netherlands, Belgium and Luxembourg. Assisted suicide is legal in Switzerland and in the US states of Washington, Oregon and Montana.

EUTHANASIA LAW BY COUNTRY

Australia

Euthanasia is now illegal in Australia. It was once legal in the Northern Territory, by the Rights of the Terminally Ill Act 1995. In 1997, the Australian Federal Government overrode the Northern Territory legislation through the introduction of the Euthanasia Laws Act 1997. Unlike the states, legislation in the Northern Territory is not guaranteed by the Australian constitution. Before this law was passed by the Australian Government, Dr Philip Nitschke helped three people by them using his Deliverence machine. Organisations such as Exit International (founded by Nitschke himself), want the government to bring back euthanasia rights to Australia. Exit made TV commercials which were banned before they made it to air in September 2010.

Belgium

The Belgian parliament legalised euthanasia in late September 2002. A survey published in 2010 showed that those who died from euthanasia (compared with other deaths) were more often younger, male, cancer patients and more often died in their homes. In almost all cases, unbearable physical suffering was reported. Euthanasia for non-terminal patients was rare.

Canada

Canadian laws on living wills and passive euthanasia are a legal dilemma. Documents which set out guidelines for dealing with life-sustaining medical procedures are under the Province’s control, in Ontario under the Health Care Consent Act 1996. While it was illegal to ‘aid and abet suicide’ under Section 241(b) of the Criminal Code of Canada, which states that this is an indictable offence with a potential fourteen year sentence if the appellant is found guilty, British Columbia’s Supreme Court struck down the section, arguing that it imposed unconscionably discriminatory burdens on severely disabled individuals that were not valid under Sections 7 and 15 of the Charter of Rights and Freedoms on June 15, 2012. Thus, Canadian euthanasia and assisted suicide law is currently in legal limbo, although Canada’s federal Parliament has until June 2013 to deal with the consequences of this decision. The Canadian Medical Association has declared neutrality on the issue.

Ireland

In Ireland, it is illegal for a doctor (or anyone) to actively contribute to someone’s death. It is not, however, illegal to remove life support and other treatment (the ‘right to die’) should a person (or their next of kin) request it. A September 2010 Irish Times poll showed that a majority, 57% of adults, believed that doctor-assisted suicide should be legal for terminally ill patients who request it.

Israel

The Israeli penal law forbids causing the death of another and specifically forbids shortening the life of another. Active euthanasia is forbidden by both Israeli law and Jewish law. Passive euthanasia is forbidden by Jewish law but has been accepted in some cases under Israeli law. In 2005, proposals were put forward to allow passive euthanasia to be administered using a switch mechanism similar to Sabbath clocks. In 2006, the Steinberg Commission was set up to look into whether life and death issues could be rethought in the context of Jewish law, which suggested that hospitals could set up committees to determine whether patients would be given passive euthanasia.

Japan

The Japanese government has no official laws on the status of euthanasia and the Supreme Court of Japan has never ruled on the matter. Rather, to date, Japan’s euthanasia policy has been decided by two local court cases, one in Nagoya in 1962, and another after an incident at Tokai University in 1995. The first case involved ‘passive euthanasia’ (shōkyokuteki anrakushi) (i.e. allowing a patient to die by turning off life support) and the latter case involved ‘active euthanasia’ (sekkyokuteki anrakushi) (e.g. through injection). The judgements in these cases set forth a legal framework and a set of conditions within which both passive and active euthanasia could be legal. Nevertheless, in both of these particular cases the doctors were found guilty of violating these conditions when taking the lives of their patients. Further, because the findings of these courts have yet to be upheld at the national level, these precedents are not necessarily binding. Nevertheless, at present, there is a tentative legal framework for implementing euthanasia in Japan.

In the case of passive euthanasia, three conditions must be met:

1. The patient must be suffering from an incurable disease, and in the final stages of the disease from which he/she is unlikely to make a recovery
2. The patient must give express consent to stopping

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treatment, and this consent must be obtained and preserved prior to death. If the patient is not able to give clear consent, their consent may be determined from a pre-written document such as a living will or the testimony of the family.

3. The patient may be passively euthanised by stopping medical treatment, chemotherapy, dialysis, artificial respiration, blood transfusion, IV drip, etc.

For active euthanasia, four conditions must be met:

1. The patient must be suffering from unbearable physical pain
2. Death must be inevitable and drawing near
3. The patient must give consent. (Unlike passive euthanasia, living wills and family consent will not suffice)
4. The physician must have (ineffectively) exhausted all other measures of pain relief.

The problems that arose from this, in addition to the problem faced by many other families in the country, has led to the creation of “bioethics SWAT teams”. These teams will be made available to the families of terminally ill patients in order to help them, along with the doctors, come to a decision based on the personal facts of the case. Though in its early stages and relying on “subsidies from the Ministry of Health, Labour and Welfare” there are plans to create a non-profit organisation to “allow this effort to continue.”

**Luxembourg**

The country’s parliament passed a bill legalising euthanasia on 20 February 2008 in the first reading with 30 of 59 votes in favour. On 19 March 2009, the bill passed the second reading, making Luxembourg the third European Union country, after the Netherlands and Belgium, to decriminalise euthanasia. Terminally ill people will be able to have their lives ended after receiving the approval of two doctors and a panel of experts.

**Mexico**

In Mexico, active euthanasia is illegal but since 7 January 2008 the law allows the terminally ill – or closest relatives, if unconscious – to refuse medication or further medical treatment to extend life (also known as active euthanasia) in Mexico City, in the central state of Aguascalientes (since 6 April 2009) and, since 1 September 2009, in the Western state of Michoacán. A similar law extending the same provisions at the national level has been approved by the senate and an initiative decriminalising active euthanasia has entered the same legislative chamber on 13 April 2007.

**Colombia**

In a 6-3 decision, Colombia’s Constitutional Court ruled May 20, 2010 that “no person can be held criminally responsible for taking the life of a terminally ill patient who has given clear authorisation to do so,” according to the Washington Post. The court defined “terminally ill” person as those with diseases such as “cancer, AIDS, and kidney or liver failure if they are terminal and the cause of extreme suffering,” the Post reported. The ruling specifically refused to authorise euthanasia for people with degenerative diseases such as Alzheimer’s, Parkinson’s, or Lou Gehrig’s disease.

**Netherlands**

In the 1973 “Postma case” a physician was convicted for having facilitated the death of her mother following repeated explicit requests for euthanasia. While upholding the conviction, the court’s judgement set out criteria when a doctor would not be required to keep a patient alive contrary to their will. This set of criteria was formalised in the course of a number of court cases during the 1980s. In 2002, the Netherlands passed a law legalising euthanasia including physician-assisted suicide. This law codifies the twenty year old convention of not prosecuting doctors who have committed euthanasia in very specific cases, under very specific circumstances. The Ministry of Public Health, Wellbeing and Sports claims that this practice “allows a person to end their life in dignity after having received every available type of palliative care.” The United Nations has reviewed and commented on the Netherlands euthanasia law.

In September 2004 the Groningen Protocol was developed, which sets out criteria to be met for carrying out child euthanasia without the physician being prosecuted.

**New Zealand**

Assisted suicide and voluntary euthanasia remain illegal in New Zealand under Section 179 of the New Zealand Crimes Act 1961, which renders it a criminal offence to ‘aid and abet suicide’. There have been two prior decriminalisation attempts – the Death With Dignity Bill 1995 and the Death With Dignity Bill 2003. Both failed, although the latter only did so by a three-vote margin within the New Zealand Parliament. As of May 2012, Labour Party of New Zealand MP Marian Street is expected to introduce a private member’s bill into the ballot box,
which may mean that such a debate will be deferred for years, given that selection of bills from the ballot box is a random process.

**Norway**

Euthanasia remains illegal, though a caregiver may receive a reduced punishment for taking the life of someone who consents to it, or for, out of compassion, taking the life of a person that is ‘hopelessly sick’. The Progress Party, is the only political party in Norway to bring the subject of euthanasia up to debate.

**Switzerland**

In Switzerland, deadly drugs may be prescribed to a Swiss person or to a foreigner, where the recipient takes an active role in the drug administration. More generally, article 115 of the Swiss Penal Code, which came into effect in 1942 (having been written in 1918), considers assisting suicide a crime if and only if the motive is selfish.

Euthanasia is strictly forbidden in Turkey. The aide who helped a person to suicide or other ways to kill oneself will be punished for assisting and encouraging suicide under the stipulation of article 84 of the Turkish Criminal Law. In condition of active euthanasia, article 81 of the same law sets forth that any person who carries out this act will be judged and punished for life imprisonment just like a simple murder.

**United Kingdom**

Euthanasia is illegal in the United Kingdom. Any person found to be assisting suicide is breaking the law and can be convicted of assisting suicide or attempting to do so. Between 2003 and 2006 Lord Joffe made four attempts to introduce bills that would have legalised voluntary euthanasia – all were rejected by the UK Parliament. Currently, Dr Nigel Cox is the only British doctor to have been convicted of attempted euthanasia. He was given a 12-month suspended sentence in 1992.

In regard to the principle of double effect, in 1957 Judge Devlin in the trial of Dr John Bodkin Adams ruled that causing death through the administration of lethal drugs to a patient, if the intention is solely to alleviate pain, is not considered murder even if death is a potential or even likely outcome.

**United States**

Active euthanasia is illegal in most of the United States. Patients retain the rights to refuse medical treatment and to receive appropriate management of pain at their request (passive euthanasia), even if the patients’ choices hasten their deaths. Additionally, futile or disproportionately burdensome treatments, such as life-support machines, may be withdrawn under specified circumstances and, under federal law and most state laws only with the informed consent of the patient or, in the event of the incompetence of the patient, with the informed consent of the legal surrogate. The Supreme Court of the United States has not dealt with ‘quality of life issues’ or ‘futility issues’ and appears to only condone active or passive ‘euthanasia’ (not legally defined) when there is clear and convincing evidence that informed consent to the euthanasia, passive or active, has been obtained from the competent patient or the legal surrogate of the incompetent patient.

While active euthanasia is illegal throughout the US, assisted suicide is legal in three states: Oregon, Washington and Montana.

**REFERENCES**

2. Alexander, Cathy (13 September 2010). “Pro-euthanasia TV ad ban “a violation of free speech”. The Age (Melbourne).
7. The Irish Times (17 September 2010) – ‘Majority believe assisted suicide should be legal’.
22. ‘Observations of the UN human rights committee.’

On 25 May 1995, the Northern Territory of Australia became the first place in the world to pass right to die legislation. The Rights of the Terminally Ill Act lasted 9 months before being overturned by the Australian Federal Parliament. Today, Voluntary Euthanasia and Assisted Suicide are illegal in all states and territories of Australia.

The only end-of-life laws that exist are a patchwork of Advance Medical Directive and Power of Attorney laws, none of which allows a person to ask for active assistance to die. These laws operate on a state-by-state basis. Your access to these laws depends entirely on where you live.

**Advance Medical Directives**

An Advance Medical Directive is a legal document that is signed in advance to extend a person’s absolute right to refuse medical treatment into circumstances where the ability to communicate is lost. Thus even if that person is unconscious or demented, the AMD ensures the person’s wish to refuse treatment is respected.

The AMD document usually contains a list of the various treatments that a person has decided would be unacceptable to them. In Australia, an AMD document can be drawn up by anyone. What is most important, though, is whether the document has any legal status. Not all states and territories have laws which make AMDs legally binding.

Generally speaking AMDs will not be recognised by paramedics. In states where there are laws, medical professionals are legally obliged to adhere to AMDs. However, if they do not, penalties are remarkably soft.

**Appointment of a Medical Power of Attorney, agent or proxy**

Another equally important strategy to ensure your voice is heard if you are unable to communicate is the appointment of a person to make medical decisions for you. This legislation also varies depending on the state in which you live. A Medical Power of Attorney carries out the same function as an AMD document.

This person’s job is to ensure that if we lose the ability to communicate, our choice of acceptable medical treatments is respected. It is often much more effective to have an articulate person attempting to implement your wishes than a passive piece of paper.

State and territory laws are listed below.

**Australian Capital Territory**

An Enduring Power of Attorney (known also as a ‘Living Will’) is a legal document that authorises a nominated person to manage your lifestyle and financial affairs should you become incapacitated or unable to make decisions regarding your affairs.

The document must be signed by you while you have the required legal capacity to give your attorney clear and concise instructions. The attorney must sign the document also and accept the appointment.

You can appoint an attorney at any time, and attorneyship can be delayed until it is needed. You can give a doctor the responsibility to decide when attorneyship should start.


**New South Wales**

In New South Wales there is no legislation for an Advance Medical Directive (Living Will), however an Enduring Guardian can be appointed.

NSW Health’s *Using Advance Care Directives* is a document which aims to ‘provide advice to health professionals on the best practice use of advance care directives’. This document is important because it states, among other things, that an AMD (e.g. from another state)
which complies with the document’s requirements will be legally binding in New South Wales.

In regard to the appointment of an ‘Enduring Guardian’, there is a guide (containing the forms provided) available called: Enduring Guardianship in NSW – Your Way to Plan Ahead.

Northern Territory

In the Northern Territory, the Rights of the Terminally Ill Act was overturned by the Australian Parliament in March 1997 after only 9 months operation.

In its place are left the following legal options.

An Advance Medical Directive can be written at any time as long as the person is aged 18 years or older. The AMD applies only to a terminal illness (as is the case in South Australia).

There is no form available online however, information can be obtained at:

Office of Public Guardian – Darwin
Casuarina Plaza
Ground Floor
Casuarina NT 0811
Ph: (08) 8922 7161

Office of Public Guardian – Alice Springs
Flynn Drive
Alice Springs NT 0871
Ph: (08) 8951 6741

While no specific medical agent or proxy can be appointed in the NT, you can appoint a general Enduring Power of Attorney. For the form to be valid, however, it must be registered and lodged at the Registrar-General’s Office. A fee is payable.

Queensland

The Powers of Attorney Act (1998) in Queensland allows for an Advance Directive and an Enduring Power of Attorney for personal/health matters. Amendments passed in 2001 allow proxies or agents to consent to the withdrawal and/or withholding of medical treatment if a doctor considers these to be futile.

A Statutory Health Attorney is someone who is allowed to make these decisions for you. They are usually a partner, close relative or carer and must be over 18 years old.

A tribunal can consent to the withdrawal/withholding of life-sustaining treatment. The form in question is called an Advanced Health Directive. A paper version is available widely at newsagents.

South Australia

In South Australia, the Medical Treatment and Palliative Care Act (1995) allows a person over 18 years of age to write an Advance Medical Directive which will is known as an Anticipatory Directive. However, this applies to a terminal illness only.

An Agent can also be appointed in South Australia as a person who can consent to the withdrawal/withholding of life-sustaining treatment, but not the withdrawal of provision/administration of food and water or pain-relieving drugs.

An explanatory brochure titled: Medical Power of Attorney and An Anticipatory Direction is available.

The necessary forms for the making of an Anticipatory Directive are contained in a document called A Guide for Those Completing an Anticipatory Direction.

The necessary forms for the appointment of a Medical Power of Attorney are contained in a document called A Guide for Those Completing a Medical Power of Attorney.

A State Register of Anticipatory Directives is operated by Medic-Alert, 216 Greenhill Road, Eastwood SA 5063, Ph: (08) 8274 0361.

Tasmania

The recently passed, but not as yet enacted, Directions for Medical Treatment Bill 2005 will allow an Advance Directive for a current condition, a terminal illness or in a persistent vegetative state.

In the meanwhile in Tasmania, individuals are able to appoint an Enduring Guardian as a substitute decision-maker.

The necessary forms are available for download from the Office of the Public Guardian, www.publicguardian.tas.gov.au/choosing-a-guardian

Western Australia

The Guardianship and Administration Act 1990 was amended by the Acts Amendment (Consent to Medical Treatment) Act 2008 to include an Advance Health Directive. Finally, West Australians have legislation to enshrine their right to refuse medical treatment for a current condition or terminal illness.

While forms are not yet available, a report of the Clinical Senate Meeting titled: Delivering a Healthy WA: Patients, Clinicians, the Law and Decisions for End-of-Life Care which was held on 21 November 2008 at the Duxton Hotel in Perth is available.

An Enduring Power of Guardianship can also be appointed as a substitute decision-maker. Applications for Enduring Power of Guardianship can be made at:

State Administrative Tribunal
Level 4
12 St Georges Terrace
Perth WA 6000
Ph: (08) 9219 3111
Tollfree: 1300 306 017

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Voluntary Euthanasia Debate

Issues in Society | Volume 359
**MEDICAL OPINION AND PRACTICE**

There is ample research evidence showing that many doctors favour choice in voluntary euthanasia, arguably more than oppose it, according to drs4vechoice.org

### INFO IN SHORT...
- Most Australians believe there should be a legal option of aid-in-dying for those suffering intolerably near the end of life.
- Most Australian doctors believe a request for hastening death can be rational.
- Aid-in-dying is already widely practised in Australia, but in secret and with no standards of practice.
- A significant proportion of Australian doctors believe that aid-in-dying should be legally available.

### PUBLIC OPINION

For over four decades a majority of Australians have believed there should be a legal option of aid-in-dying for those suffering intolerably and without relief near the end of life (Morgan and Newspoll). Current support is 85% of Australians including three out of four Catholics, four out of five Anglicans, and nine out of ten Australians with no religion.

1. **Kuhse and Singer surveyed 869 Victorian doctors (1988):**
   - 62% answered yes to the question “Do you think it is sometimes right for a doctor to take active steps to bring about the death of a patient who has requested the doctor to do this?” (64% of AMA members polled said yes)
   - 93% thought such a request could be rational
   - 50% thought that a practice similar to that in the Netherlands should be allowed
   - 52% of AMA members thought that the AMA should change its stance on the issue.

2. **Baume and O’Malley surveyed 1,268 NSW doctors (1994):**
   - 59% thought actively hastening death on request was sometimes right
   - 96% thought such a request could be rational
   - 59% thought Netherlands practice should be allowed
   - 52% thought their professional organisation should approve medically-assisted dying.

3. **Stevens and Hassan surveyed 298 SA doctors (1994):**
   - 89% thought a request to hasten death could be rational
   - 47% were in favour of legalisation of voluntary euthanasia.

4. **The RACGP surveyed 886 members (1996):**
   - 45% personally wished to have the option of voluntary euthanasia
   - 56% would not be distressed if it were available to others
   - 68% believed that euthanasia can be an act of caring
   - 45% did not believe that “present arrangements are adequate in delivering help to the dying.”

5. **Steinberg et al surveyed 259 Queensland doctors (1997):**
   - 36% thought a doctor should be allowed by law to assist a terminally ill person to die.

6. **Kuhse et al surveyed 1,918 Australian doctors about end-of-life decisions (comparable to the Dutch Remmelink studies) (1997):**
   - 1.8% of deaths were by VE or physician-assisted suicide
   - 3.5% of deaths involved termination of the patient’s life without explicit request
   - In 24.7% of deaths treatment was withheld or withdrawn with the intention to hasten death
   - In 6.5% of deaths opioids were administered with at least the partial intent to hasten death.

7. **Douglas et al surveyed 683 Australian general surgeons (2001):**
   - 36.2% reported that they had given drugs in doses greater than was necessary to relieve symptoms with the intention of hastening death
   - 20.4% reported that they had given drugs with the intention of hastening death, but without the explicit request of the patient
   - 1.9% reported assisting with a suicide
   - 4.2% reported having acceded to requests for voluntary euthanasia.

   - 53% of doctors support the legalisation of voluntary euthanasia
   - Of doctors who have experienced requests from patients to hasten death, 35% have administered drugs with the intention of hastening death.
Public opinion polls on voluntary euthanasia law reform in Australia

A fact sheet from the South Australian Voluntary Euthanasia Society

Over three quarters of Australians give an affirmative response to the following Morgan Poll question:
If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?

- In 1962, 47% said “yes” to a similar question and the percentage has steadily increased over the years.
- It was above 70% throughout the 1990s. In 1993, 1994, and 1995 78% said "yes", and 76% in 1996.
- In 2002 a Morgan Poll revealed that national support was 73% and 79% in South Australia. The percentages by religious persuasion saying "yes" in South Australia in June 2002 were: Anglican 81%, Methodist 87%, Presbyterian 66%, Roman Catholic 69%, Uniting Church 74%, Lutheran 74%, and Baptist 68%.
- In 2007 the same question was asked in a Newspoll survey, with 80% of Australians saying “yes” (81% in South Australia). Nationally 74% of respondents who stated that they had a religion gave an affirmative response to the question.
- In a 2009 Newspoll 85% of Australians gave an affirmative response (82% in South Australia).
- The 2010 survey by The Australia Institute (an independent “think tank” developing and conducting research and policy analysis, www.tai.org.au) had a 75% affirmative response to this question.
- In 2011 a Newspoll conducted in New South Wales showed an 83% affirmative response.

Although public opinion polls have their weaknesses, there can be no doubting the widespread support for allowing a hopelessly ill and suffering patient legal access to a requested medically hastened death.

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REFERENCES

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New survey shows majority support for euthanasia

The Australia Institute announces the latest euthanasia survey results

The overwhelming majority of Australians support voluntary euthanasia, according to new research released at today’s Dying with Dignity NSW 2012 Parliamentary Forum in Sydney. The nationally representative survey of 1,422 people found that 71 per cent of Australians support the legalisation of voluntary euthanasia for people experiencing unrelievable and incurable physical and/or mental suffering. Opposition to voluntary euthanasia was 12 per cent, while 17 per cent were ‘not sure’.

The survey also revealed that of those Australians who support the legalisation of voluntary euthanasia, 85 per cent also believe that terminally ill patients should have the option of choosing when they die.

The Australia Institute’s Executive Director Dr Richard Denniss said the findings show that the Australian public is way ahead of Australian parliaments when it comes to respecting the wishes of people suffering at the end of their life.

"Conservative politicians are usually quick to argue that governments shouldn’t control our lives but unfortunately many of those same politicians are more than happy to control our deaths," said Dr Denniss.

Of those respondents who supported the legalisation of voluntary euthanasia, 77 per cent believe that those with severe dementia who had previously signed an Advanced Care Directive expressing their desire to end their life should have their wishes respected. Seven per cent expressed their opposition to this question, while 16 per cent said they were ‘not sure’.


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Issues in Society | Volume 359  Voluntary Euthanasia Debate
WHO WILL FIRST HAVE THE RIGHT TO DIE?  
THE FRAUGHT EUTHANASIA LANDSCAPE

Euthanasia law reform in Australia could be closer than you think, according to this report from Crikey intern Sarah Duggan

The case of South Australian mother Joanne Dunn, who has asked doctors to stop feeding her comatose son Mark in order to let him die, has rekindled interest in euthanasia – and law reform could be closer than you think.

Mark Leigep, who is 37, has been in a vegetative state since March 2006 after sustaining head injuries in a car crash. Current laws prohibit voluntary euthanasia and assisted suicide in all states and territories, so the only legal option left for Dunn is to effectively starve her son to death.

In the UK, high-profile “locked-in syndrome” sufferer Tony Nicklinson died recently from pneumonia, just six days after losing his battle with the High Court for the legal right to end his life.

Crikey has examined the legal landscape on euthanasia (which is essentially a state issue) and found Tasmania may be the closest to legalising the practice, where a “mobile medically-assisted suicide clinic” for the terminally ill could be running by this time next year.

Philip Nitschke, director of the pro-euthanasia group Exit International, plans to launch a Tasmanian home-visit clinic program that would allow doctors to travel to patients’ homes and lawfully prescribe and administer the lethal drug Nembutal. The service would be modelled upon a Dutch version, which has been operating out of a van since March.

Nitschke’s plans would capitalise on proposed changes to euthanasia law in Tasmania. Three months ago, Greens leader Nick McKim declared he would introduce a private member’s bill, co-sponsored by Labor Premier Lara Giddings. The bill has not yet been released. McKim told The Examiner a discussion paper outlining the merits of voluntary euthanasia would be released in the coming weeks.

“Rather than seeking a discussion on whether or not we should introduce voluntary euthanasia, it will be encouraging discussion around how it should be done,” McKim said. “We will then draft and table legislation that is appropriate for Tasmania, which gives it the best chance of passing the Parliament.”

Giddings told the ABC the aim is to “try to get legislation to the Parliament by the end of the year”, but that “as we progress through we’ll know whether or not we can actually meet that timetable”. She added that “it is possible to carefully and sensitively improve end-of-life decision-making through a safe and regulated legal and medical framework”.

Neil Francis, president of Dying with Dignity, confirms the Tasmanian discussion paper will soon be released. “The law prohibiting euthanasia is seriously out of step with the will of the people. Three out of four Catholics, four out of five Anglicans and nine out of 10 non-faith Australians believe that euthanasia should be legalised,” Francis told Crikey.

Other states are considering euthanasia laws too. In South Australia, Labor MP Stephanie Key’s “Consent to Medical Treatment and Palliative Care (End of Life Arrangements) Amendment Bill 2010” has been tabled. The bill would enable South Australian GPs who administer drugs to end a patient’s life to obtain a legal defence to the charges of murder, manslaughter or assisting suicide. Key says the bill will amend the state’s Criminal Law Consolidation Act, but the changes will not lead to the decriminalisation of euthanasia.

“What it is saying is that in certain circumstances, if someone is at the end of the road and the palliative care measures have not effectively reduced the person’s suffering to an acceptable level, then the doctor can accede to [the patient’s] requests,” Key said.

A new motion is planned in the Victorian upper house to consult publicly on “end-of-life decision making”. The public’s response may then inform the drafting of a revised euthanasia bill. In NSW, Greens MP Cate Faehrmann plans to introduce a bill to the Legislative Council in November to legalise voluntary euthanasia.

At the federal level, former Greens leader Bob Brown put forward the “Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010”, which aimed to reinstate the rights of the territories to legislate on voluntary euthanasia. It’s been before the Senate since 2010. (The NT briefly legalised euthanasia, but those laws were overruled by the Howard government.)

In his second reading speech to parliament in 2010, Brown outlined the bill’s objectives:

“The first is to recognise the rights of the legislative assemblies of the Australian Capital Territory, the Northern Territory and Norfolk Island to make laws for the peace, order and good government of their territories, including the right to legislate for voluntary euthanasia. Secondly, and more directly, the bill repeals the Euthanasia Laws Act 1997, the Andrews Act, which removed the right of the territories to legislate on voluntary euthanasia.”

A spokesperson for Greens leader Christine Milne told Crikey the bill was “not scheduled for debate at this stage” and was likely to fail because it had not secured political support. Meanwhile, in the South Australian suburb of Fullarton, Mark Leigep lies unresponsive as his future is decided.

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Euthanasia is a policy issue in Australia that has yet to be seriously tackled let alone resolved. Green Party Senator Bob Brown’s private member’s bill, Restoring Territory Rights (Voluntary Euthanasia Legislation) Bill 2010, that is still before the Senate, reminds us that while euthanasia is not presently top of the policy agenda, there is still the potential for legislation to be passed in the life of the present Commonwealth Parliament. Senator Brown’s bill would give the ACT and NT legislatures the power to legalise euthanasia – whether they would choose to do so or not is another question.

It is also still in the realms of possibility that the current Gillard Commonwealth Government could decide to legislate nationally on euthanasia, if it judged such action to be both constitutional and popular and given its dependency on the Greens for survival. While the constitutional power of the Commonwealth to legislate to either permit or prohibit euthanasia is open to question, few questions are asked about the nature of the supposed overwhelming public support for legalising euthanasia and just what the long term implications might be across a range of other policy areas.

Majority rules in a democracy – does it or should it?

The overwhelming popular acceptance of euthanasia is assumed from the 85 per cent of Australians who responded positively to a single loaded question in a Newspoll survey in 2009:

If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?

Such a confronting, personalised characterisation of the issue of euthanasia ignores its many complexities and subtly muddies the waters around the current legal position of pain relief to the terminally ill. Yet such a level of popular support must be almost irresistible for many of our politicians who see their role in a democracy as reflecting voters’ opinions. While in a democracy majority opinion matters and there is a political risk in resisting it, there is at least an equal risk for government and the future wellbeing of our society in introducing bad policy that ignores the full complexity of an issue like euthanasia.

Euthanasia as a ‘wicked’ policy problem

What makes euthanasia such a difficult issue to address is that it falls into what is defined as a ‘wicked’ policy problem. ‘Wicked’ policy problems are so labelled not because they are ‘evil,’ but because they are highly complex, difficult to understand, resistant to solving and have profound implications for the fundamental institutions of society. ‘Wicked’ problems are more than just complex, despite a temptation to label all complex social problems ‘wicked’.

Wicked problems go beyond complexity to encompass uncertainty and divergent values and beliefs. They have a number of characteristics: there are conflicting and diverse definitions of the problem; there is no easy solution to everyone’s satisfaction; they are immune to resolution by appeal to the facts and evidence; they cross institutional and conceptual boundaries; they are unbounded in scope, with implications for other policy areas which are not readily understood or predicted; and they usually require action by many individuals and organisations as well as government.

‘Wicked’ policy problems tend to thrive and increase in a pluralist society like Australia’s. As ethicist Margaret Somerville (2004:5) points out, “In this type of society (pluralist, secular, multicultural), we no longer automatically have access to a received set of values through a shared religion, and we can no longer impose values or assume there is a consensus on them.”

Euthanasia fits the definition of a ‘wicked’ problem well. It has certainly defied solution, as shown by the history of attempts to legalise euthanasia at both state and Commonwealth level in Australia and in other countries. Since 1995, every Australian state and territory except Queensland, introduced a form of euthanasia legislation which subsequently was either defeated or overturned or lapsed. Overseas where euthanasia legislation has been enacted – notably the Netherlands, Belgium, Switzerland, Luxembourg and Oregon and Washington in the USA – the passage of the law has rarely been the end of the matter. Legal challenges abound, even where the law has only been passed after extensive public consultation. In the UK and Canada, despite comprehensive public inquiries, the legal and ethical status of assisted dying remains an unresolved public policy issue.

Profound disagreement about the nature of the problem is a feature of euthanasia as a public policy issue. The accepted definition is “a deliberate act that causes death undertaken by one person with the primary intention of ending the life of another person, in order to relieve that person’s suffering.” Euthanasia is thus easily confused with other end of life practices, such as using medication to ease pain and suffering, which may hasten death; avoiding treatment and intervention that prolongs the process of dying; switching off life support; and refusing treatment. Further ambiguity exists in the different forms euthanasia may take – assisted suicide, physician-assisted suicide, voluntary and non-voluntary euthanasia and assisted dying.

This confusion of meaning is underlined by uncertainties in elements of the definition as it applies to people.
A distinguishing characteristic of euthanasia as a public policy problem is its moral dimension. It goes to the fundamental principles on which society is based and challenges long-established, previously widely shared societal values. In the absence of institutionalised religion and in the face of the diversity of views in a pluralist, secular society, policymakers and politicians need to search for an ethical base and confront conflicting values.

One of the most commonly raised objections to changing the law to allow euthanasia is the slippery slope argument, a concern with potential abuse, the difficulty of setting secure limits and unintended adverse consequences. The slippery slope argument suggests that legalisation of assisted suicide will lead inexorably to acceptance of other kinds of non-voluntary deaths. This was a major concern for the British House of Lords Select Committee on Medical Ethics in 1994 which concluded that it was impossible to set secure limits on voluntary euthanasia:

To create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation.

While some argue that the law can provide safeguards against the slippery slope effect, others are doubtful and advocate the adoption of the ‘precautionary principle’, an established principle in environmental policy, which has two main elements: the need to anticipate harm before it occurs; and an obligation, if the level of harm is high, for cautious action. This year in the UK after an extensive process of public debate and exchange of views, the Falconer Commission on Assisted Dying came to a different conclusion from the House of Lords inquiry, supporting a new safeguarded framework to permit terminally ill people to end their own life, finding this preferable to the uncertainties of the current “inadequate and incoherent” legal framework.

**Tackling ‘wicked’ policy problems in Australia**

How does a pluralist society like Australia where many policy issues get too easily categorised into partisan political camps before we even have a debate, deal with euthanasia? Should we just act on popular sentiment as fuelled by questionable opinion polling? After all, Australia has done well in the past in managing considerable policy change such as reorientating our economy and having a sustainable welfare system, so why cannot we also tackle euthanasia effectively?

There are three basic requirements for dealing with ‘wicked’ policy problems like euthanasia.

First, there needs to be time to engage the public in open, depoliticised, iterative discussion of the many dimensions of the problem. This is an absolute necessity for complex social issues with a strong moral dimension like euthanasia, in order to make different perspectives understood and create a shared understanding of the issue to address.

Second, there needs to be reliable evidence and data so...
as to inform the debate and avoid distortion of the facts, but this alone is not sufficient when conflicting values and perspectives are at stake. Euthanasia is not an issue where ‘evidence’ based policy development alone can resolve the matter, but we certainly need to clarify the ‘evidence’.

Third, it is essential to have appropriate mechanisms (more than one) for public engagement in informed debate, to explore the range of arguments and to encourage the consideration of wider social implications if an agreed policy solution for the common good is to emerge.

Engaging the public in this kind of policy process would be a welcome new feature in the Australian political process. In recent years, that process has been characterised by: rushed policy development and demands for ‘instant’ policy solutions; flawed policy processes; trivialisation and politicisation of national policy discourse; and a high degree of distrust of politicians and key institutions. Complex policy problems defy simplistic and populist solutions and call for thorough and extensive public discussion and ‘cool’ debate. Providing the opportunity for people to think more fully and seriously about important public issues, to be part of a meaningful dialogue and deliberation that acknowledges different values and beliefs, is more likely to lead to a sound and lasting policy solution than an adversarial approach or the ‘tyranny of the majority’.

REFERENCES
► House of Lords, Select Committee on Medical Ethics, May 1994 and Hansard, May 9, 1994, vol 554 cc1344-412.; and debate: para 238.

Scott Prasser is executive director of the Public Policy Institute at the Australian Catholic University.

First published in Health Matters, Winter 2012 Catholic Health Australia | www.cha.org.au

Unclear end-of-life concepts cloud euthanasia debate

A genuine public debate on ‘legalising euthanasia’ can only happen after a clear distinction is made between assisted suicide and euthanasia and the withholding, refusal, or withdrawal of life-sustaining measures, writes Queensland University of Technology law academic Dr Andre McGee

Dr Andrew McGee, whose article on the subject has been published in the international journal, Legal Studies: Journal for the Society of Legal Scholars, said the preparation of a new private members bill for voluntary euthanasia recently announced by the Tasmanian Premier, Lara Giddings, may not reflect public support for such a bill, because the surveys on which the assessment of public opinion was based were flawed.

“It has been claimed that a survey showed 80 per cent of people in Tasmania are in favour of euthanasia, but the Parliamentary report on the bill in which these findings are presented itself concedes that the wording of the survey was confused,” Dr McGee said.

“The report expressly states that it is unclear whether respondents considered the withdrawal of, non-commencement of, or refusal of life-prolonging treatments as voluntary euthanasia.

“So this means that respondents to the survey might have merely confirmed their support for withdrawal, withholding or refusal of treatment which is conduct that is already lawful. The results of the survey, therefore, are not a secure basis for changing the law.”

Dr McGee said laws in this area were often criticised by the legal profession for being confused and inconsistent.

“For example, a common argument made by proponents of euthanasia is that it is already lawful in some forms, where, for example, a doctor can withhold life-support or switch off a life-support machine,” Dr McGee said.

“On this view, it is illogical that administering a lethal dose is unlawful, while withholding and withdrawing life support is permitted.

“But this argument takes for granted that withholding and withdrawing life support really is a form of euthanasia, and so begs the question and only clouds the real issues that need to be debated.

“The issue should simply be whether we should accept that, in some circumstances, it is right to allow people to end their lives early to avoid unbearable pain and suffering. If the answer is ‘yes’ then we should focus on defining what those circumstances are in a way that does not open the floodgates.

“This should not be confused though with the issue about when doctors might stop prolonging life by withdrawing life-prolonging treatment. The law about life-prolonging treatment is already settled.”

He said there was growing public demand for clearly defined legislation on end-of-life decisions.

“People with terminal illnesses want absolute assurance that their loved ones would not be implicated; another reason is that people want the decision to end their own life to stop their suffering legitimised. There is still a stigma attached to suicide,” Dr McGee said.

“In a recent British case the director of public prosecutions was instructed to issue guidelines on when prosecutions would be brought against people who might assist another to end their life.

“The confusion in the public mind surrounding the terms or concepts involved needs clarification, so everyone understands fully what is at stake. Only then can we have a proper and meaningful debate.”

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Voluntary euthanasia and assisted suicide are never far from the public spotlight. But we still haven’t had an honest and open debate about this issue in Australia.

End-of-life matters crop up from time to time, for example, when there’s a new bill proposing liberalising the law or when someone is prosecuted for being involved in the death of a loved one. And when such events are reported in the news, there’s usually a short period of public interest. But once the episode concludes, that interest subsides and life (and death) goes on as before.

Putting aside the efforts of long-standing advocates and opponents of voluntary euthanasia and assisted suicide, sustained engagement by the wider public with these issues is glaringly absent – despite overwhelming public support for reform. And despite the trend of liberalisation overseas. That tide of international reform is likely to soon reach our shores, although we note the recent narrow defeat of the ‘Death with Dignity’ initiative in Massachusetts.

Arguments about autonomy and the sanctity of life in this debate are well understood, at least on some level, by the wider public. But a likely gap in public awareness is the significant body of empirical evidence gathered over many years on the operation of permissive jurisdictions, such as the Netherlands.

Understanding what the data are saying can be difficult. Indeed, different commentators point to the same statistics in reaching diametrically opposed conclusions. But how this data are used influences the honesty of the dialogue. A public debate that considers the data and its interpretations provides the opportunity to assess common concerns about voluntary euthanasia and assisted suicide, such as ‘slippery slopes’ and the possible harm to vulnerable people.

Honest engagement would also allow a more nuanced assessment of the blanket claims that are sometimes made by both the advocates and the opponents of reform.

Engagement with the available evidence is the precursor for rational dialogue. It would allow for debate that’s based on evidence rather than just on what we believe or simply assert. Although beliefs are a justifiable part of these deliberations, it nonetheless needs to be a debate that’s intellectually curious and genuinely open to both sides’ understanding of the other’s position.

The debate must also be honest – honesty is required from everyone involved or influential in this dialogue. Honesty allows genuine differences to be known and respected, and enables the focus to shift to these points.

It’s particularly important that our
politicians are honest. An interesting disconnect in this area is the lack of legislative action in the face of overwhelming public support for reform. It’s not entirely clear why this is so but some commentators suggest it’s due to a fear of the political harm that can come from religious groups who oppose voluntary euthanasia and assisted suicide.

A parliamentary bill proposing liberalisation of the law is likely to be decided by a conscience vote. And the electorate is entitled to know how their representative will vote and why. Politicians should be honest in their engagement with this issue, and make clear the basis on which they support or oppose reform. The public needs to question why they fail to do this.

A new opportunity for the debate
The independent, not-for-profit research group Australia21 has today released a background paper that we wrote entitled How should Australia regulate voluntary euthanasia and assisted suicide? The goal of the paper is to provide the basis for considering this issue. We hope this heralds a new dawn of engagement, so the wider public – and not just the long-standing opponents and advocates of reform – take part in an sustained debate.

Two things are critical to preparing the ground for a public debate in Australia and to ensuring it is of a high level – public engagement with the available evidence and a rational, honest dialogue.

This is a chance to put aside some of the sloganism and rhetoric that sometimes dominate the public and political discourse in this area and instead promote a rational, honest debate that properly considers the empirical evidence about voluntary euthanasia and assisted suicide.

DISCLOSURE STATEMENT
Ben White and Lindy Willmott received a small honorarium from Australia21 to write the background paper referred to in this article. She and Ben White also acknowledge the input of Australia21 during the writing process of that paper but are, of course, responsible for its final content.

Ben White is Professor of Law at Queensland University of Technology.
Lindy Willmott is Professor of Law at Queensland University of Technology.

How should Australia regulate voluntary euthanasia and assisted suicide? Australia 21 Background Paper, released November 2012. This report can be downloaded from www.australia21.org.au

WHOSE BODY IS IT? ETHICAL AND RELIGIOUS RESPONSES TO EUTHANASIA

There are two issues that need to be addressed before we can even broach the ethics of euthanasia, asserts Rabbi Jeffrey Cohen

The religious response is by far the most complex, for there can hardly be considered a single religious response. Here, as in other cases, there is a wide range of opinions as the matter is examined through the various prisms which influence what moral, ethical and religious values one applies.

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in a number of places including Switzerland, Germany, Japan, Oregon, Washington, and Texas. Although it is legal in Belgium and The Netherlands it still is considered a homicide although it is not prosecuted if certain safeguards are followed. It was also legal for a short period of time in the Northern Territory of Australia which went into force on 1 July 1996 and operated for about nine months before being overturned by the Commonwealth of Australia in 1997.

The Governor of Colorado (1975–1987) Richard Lamm has argued that “we have a duty to die.” He has been a strong advocate of physician-assisted suicide and argues that the world is getting too crowded and as we age we have a duty to make way for those who are younger.

This is an extension of the argument propounded by Daniel Callahan of the Hastings Center who argued for the rationing of medical services once an individual reached a certain age.

The argument made by Callahan, and even more so Lamm, is that the older we get and the more of a drain on resources we become, the greater is our duty to die. A very utilitarian approach which has some reinforcement when one visits nursing homes.

This theme is carried to its logical conclusion in Kurt Vonnegut’s short story, Welcome to the Monkey House, where the world has become very overpopulated, and the government takes drastic actions including the encouragement that citizens painlessly end their lives in ‘ethical suicide parlours’.

Perhaps the strongest argument concerning euthanasia stems from the experience of pain as one approaches the end of life. Some advocates of palliative care argue that pain management is sufficiently developed that euthanasia is unnecessary.

There seem to be two holes in that argument. First there is a small percentage for whom pain management is not sufficient. Second, the very use of the opiates such as morphine can actually hasten the death of the patient.

The US state of Oregon does not consider physician-assisted suicide as euthanasia under the Oregon Death with Dignity Act. Clearly the language of the act is back to front, for it should be advocating that physician-assisted euthanasia is not suicide.

It is here we need to return to the prism established at the beginning. Will the person who chooses voluntary euthanasia be treated by their community as a suicide? In some faith communities the answer is yes – and therefore will not be allowed to be buried in consecrated ground. Other faith communities will take a more lenient position and permit such a burial.

All the discussion about euthanasia is about the active involvement of the person. Each model has a series of built in safeguards.

Perhaps the strongest argument concerning euthanasia stems from the experience of pain as one approaches the end of life.

The other extremes of euthanasia, which is often used by those opposing it in any form, are the experiences of Nazi Germany and eugenics in both Germany and the United States especially between the first and second World Wars.

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Euthanasia and physician-assisted suicide

POSITION STATEMENT FROM PALLIATIVE CARE AUSTRALIA

Palliative Care Australia believes:

- Euthanasia and physician-assisted suicide are not part of palliative care practice
- Every Australian at the end of life should have timely and equitable access to quality, needs-based and evidence-based care
- Dying is a natural part of life, and declining or withdrawing aspects of treatment is acceptable if it aligns with the informed wishes of the patient. This does not constitute euthanasia or physician-assisted suicide
- There are a wide range of views and perspectives in the Australian community about the ethical issue of the deliberate ending of life for a person living with a terminal condition. PCA recognises and respects the diversity of personal, religious and cultural views of people and encourages open and honest discussion
- Much community interest in euthanasia and physician-assisted suicide is sparked by a need for assurance that pain and suffering will be relieved and that individual end of life decisions will be respected. Many of these fears can be addressed through the provision of quality care at the end of life that includes the opportunity for individuals to articulate care preferences through advance care plans, for future circumstances in which they may no longer be able to express their wishes
- Informed discussion about euthanasia and physician-assisted suicide is hindered by our failure as a society to guarantee access to quality care at the end of life
- The Australian community needs to openly discuss death and dying in order to recognise that dying is a natural and expected part of life. Engagement in advance care planning will greatly contribute to this discussion

Palliative Care Australia calls for:

- The development of health and social policy that:
  - Affirms death as a natural part of life
  - Actively supports those who are dying, their families and their carers
  - Informs the Australian community about all aspects of quality care at the end of life
  - Accepts quality care at the end of life as a basic human right
  - Allocates sufficient resources to enable access to quality end of life care, including specialist palliative care for all, in accordance with PCA’s population-based approach.
- Promotion of informed community discussion about death and dying including ongoing communication initiatives
- Development and implementation of initiatives designed to increase community and health professional capacity to consider and plan for quality end of life care
- Development and roll out of national guidelines and systems to promote good practice in advance care planning, as outlined in the PCA Position Statement on Advance Care Planning.1

DEFINITIONS

Palliative care as defined by the World Health Organisation is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

- Palliative care provides relief from pain and other distressing symptoms:
  - Affirms life and regards dying as a normal process.
  - Intends neither to hasten nor postpone death.
  - Integrates the psychological and spiritual aspects of patient care.
  - Offers a support system to help patients live as actively as possible until death.
  - Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated.
  - Will enhance quality of life, and may also positively influence the course of illness.
  - Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

Euthanasia is the act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intractable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.3

Assisted suicide is the act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intractable suffering, in order that that person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.3

NOTES


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18 Voluntary Euthanasia Debate

Issues in Society | Volume 359
PLANNING YOUR ENDEGAME: ADVANCE CARE DIRECTIVES

Can we be forced to live despite our wish to have our lives end at some natural point? What options do we have for having a say in how and when we are to die? Colleen Cartwright looks at the main recourse for having a say in how our lives end.

Many people in the community fear the end stage of life, not because they’re afraid of dying but because they fear such things as the loss of mental faculties, control and dignity, being a burden on family and not receiving adequate pain relief.

This is often the result of having witnessed distressing deaths of loved ones, as illustrated in cases such as these:

Daughter: Mum always said she wouldn’t want to be resuscitated if her heart stopped, but they wouldn’t listen.

Wife: First of all he was stubborn when he was in hospital; he wouldn’t eat – he was just starving himself... so they had to force-feed him. They put a tube down his nose and then they had to tie him in the bed, because he kept pulling it out. He just didn’t want it.

Every competent person has a right to refuse treatment – even life-saving treatment – and the cases above are actually assault under the law in Australia.

Advance Care Planning provides a way for competent people who fear aggressive end-of-life treatment to record their wishes. This is often the result of the loss of mental faculties, control and dignity, being a burden on family and not receiving adequate pain relief.

There are two ways to do this: one is to write down your wishes in an Advance Directive; the second way is to appoint someone to make decisions for you once you’re no longer capable of deciding for yourself. Doing both gives greater certainty.

**Advance directives**

An Advance Directive is a written document that ensures a person’s wishes are known. It also assists healthcare providers to make decisions in line with what the patient desires and – because Advance Directives are legally binding in every state and territory in Australia – it gives people confidence that their wishes will be carried out.

You can also appoint a substitute decision maker (called an Enduring Guardian, Medical Agent or Enduring Power of Attorney for health matters) to make personal, lifestyle and/or medical and dental treatment decisions on your behalf, in case you lose the capacity to do so yourself.

This option is available in every state and territory except the Northern Territory, and the appointed person is usually a trusted relative or friend.

You can also appoint more than one substitute decision maker and say how they’re to make the decisions. The chosen person must agree to the appointment, should understand your wishes and be prepared to carry them out.

The appointment must be in writing. The form must be signed by the person choosing their substitute decision maker/s; by the person or people appointed and; by an independent witness (depending on the state or territory this might be a solicitor, a justice of the peace or a Registrar of the Courts).

**What if no one has been appointed?**

If there’s no Advance Directive and you haven’t appointed a substitute decision-maker, the legislation in each state/territory provides for decisions to be made by the first person in a specified list.

In most states and territories, the order of authority starts with spouse (including de facto or same-sex spouse) and if there’s no spouse it moves to a non-professional carer. If there’s no carer, it’s usually a close relative or friend of the patient.

It’s important to note that that the order of authority isn’t based on next-of-kin and the person who has the legal right to make healthcare decisions may not be the person the patient themselves would’ve chosen.

**How well do such arrangements work?**

There’s a great deal of confusion in hospitals, residential aged-care facilities, and in the general community about Advance Care Planning (ACP). This confusion not only means that patients’ wishes for end-of-life care are often not respected, but it can also put health-care providers at risk of serious legal consequences.

Part of the confusion is caused by the fact that the law relating to ACP is different in every Australian state and territory, each of which uses different terminology and different documents. To start to address this issue, the Australian Government recently released the National End-of-Life Framework, which is promoting Advance Care Planning consistency across Australia.

A full listing of the laws in each state and territory can be found at the end of a discussion booklet End-of-life care for people with dementia published by Alzheimer’s Australia.

Most people want at least a measure of predictability and self-determination in relation to death and dying. Advance Care Planning can help to provide that.

**Colleen Cartwright is a Professor and Director, ASLaRC Aged Services at Southern Cross University.**
I have been asked to address the ethical arguments for and against euthanasia. I will begin with a brief definition of euthanasia and leave it to my colleague to spell out some of the necessary distinctions.

Euthanasia is “an action or an omission which of itself and by intention causes death, with the purpose of eliminating all suffering.” (EV n. 65). So it is the intentional killing of another with the aim of thereby relieving suffering. The causing of death is the means to relieving the suffering.

I would expect that in the future, rather than bills seeking to legalise euthanasia as such, we will see the emphasis move to legalising assisted suicide along the model of the legislation in Oregon, USA.

I will not go into the various attempts in different States to legalise euthanasia. As of yet, none have succeeded, except for the earlier ‘success’ in the Northern Territory. However, some of the votes have been close.

In what follows, when I say euthanasia it includes assisted suicide unless otherwise stated.

So let’s turn to the arguments. First of all we need to distinguish between the moral arguments for and against euthanasia in itself, from the arguments for and against legalising euthanasia.

For those in favour of euthanasia, the moral arguments for euthanasia and the arguments for legalising euthanasia are more or less the same. But the arguments against legalising euthanasia are not all the same as the moral arguments against euthanasia itself. Indeed one might not object to euthanasia as such, but object to the legalising of euthanasia.

In a democratic society one’s claim to liberty to do something has to be measured against the rights of others and the demands of the common good.

This happened with the House of Lords committee in England in 1994 where a majority of members had no objection to voluntary euthanasia, but arrived at the conclusion that you could not legislate to allow voluntary euthanasia.

Most of the debate in the public forum is about whether
or not euthanasia should be legalised. As I said, more and more the debate is about legalising medically-assisted suicide, although some do argue for and against the morality of euthanasia itself.

The arguments against the legalising of euthanasia focus upon the common good.

In a democratic society one’s claim to liberty to do something has to be measured against the rights of others and the demands of the common good. Sometimes we cannot exercise apparent liberties because to do so would have a detrimental effect on the common good of society, and hence a detrimental effect on other innocent members of society.

It is the various threats to the common good that have generally won the day when arguing against the legalising of euthanasia. Of course, people can have different conceptions of what is meant by ‘the common good’, and it is something about which we could have much more discussion in the public forum. But nearly any conception of the common good will include maintaining conditions which enable people to live their lives with a sense of security free from threat from others.

Aspects of the common good affected by the legalisation of euthanasia would include equal protection under the law, the ethos of the practice of medicine, and factors affecting an individual’s sense of security at times when they are particularly vulnerable.

The prohibition of intentional killing

Fundamental to a well functioning and just society is the prohibition of intentional killing. Sometimes this is expressed as the ‘sanctity of life’ principle or the ‘inviolability of life’ principle. In the western world this concept owes much to the Judaeo-Christian tradition which affirms that every individual is made in the image and likeness of God.

However the inviolability of human life is not something known only through divine revelation. The concept is found in the pre-Christian Hippocratic Tradition and in contemporary international conventions such as the European convention which states: “Everyone’s right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.” The concept expresses the belief that human life possesses an intrinsic dignity which grounds the principle that one must never express the belief that human life possesses an intrinsic dignity which grounds the principle that one must never.

In 1994 The House of Lords Select Committee on Medical Ethics (England) delivered its report on euthanasia. After hearing evidence from numerous people, and after a delegation visited the Netherlands to study its practice of euthanasia, the committee stated:

“Ultimately .. we do not believe that these arguments [for euthanasia] are sufficient to weaken society’s prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal.

We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia. We acknowledge that there are individual cases in which euthanasia may be seen by some to be appropriate. But individual cases cannot reasonably establish the foundation of a policy which would have such serious and widespread repercussions. Moreover dying is not only a personal or individual affair. The death of a person affects the lives of others, often in ways and to an extent which cannot be foreseen. We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.”

The position of the House of Lords Committee upholds the ‘sanctity/inviolability of life’ principle. This principle affirms the equal basic worth and dignity of every person. It is the foundation of our justice system as it gives a non-arbitrary and non-discriminatory way of identifying who are the subjects of justice. The legalisation of voluntary euthanasia would undermine this foundational principle to the detriment of the innocent.

We believe that the issue of euthanasia is one in which the interest of the individual cannot be separated from the interest of society as a whole.

Autonomy and ‘best interest’

As mentioned earlier some claim the liberty to request their life be ended by others. They appeal to the good of ‘autonomy’, the right to be able to choose for oneself. However, the argument for euthanasia is not built solely upon the supposed principle of autonomy. It invariably also relies upon some kind of ‘best interest’ argument, in this case that it is in someone’s best interest to be dead rather than alive under the prevailing circumstances. In other words, the judgement is made that someone’s life is not worth living.

According to advocates of voluntary euthanasia that judgement is made by the one wishing to be killed. Once this principle is accepted then everyone’s life is at risk. If it is theoretically possible to arrive at a judgement that one’s life is not worthwhile then why should others not be able to arrive at that judgement regarding other persons. Indeed even in response to requests for euthanasia the doctor has to more or less concur with the patient’s judgement. The doctor will have to judge that a particular life is not worthwhile.

As the House of Lords indicated a sound system of justice is founded upon the notion of the equal dignity of all. To permit some lives to be judged as no longer worth living and to be intentionally killed undermines the protection of all.

Professor John Finnis expresses it well:

“If one claims a right to suicide, assistance in suicide and/or euthanasia, one is making a claim which is not and rationally cannot be limited by reference to one’s own
particular identity and circumstances. Nor can it plausibly be restricted to cases where the person to be killed has autonomously chosen to act on one or both of the two (erroneous) judgements. For the first judgement claims that death – and thus being killed – is no harm (indeed may be a benefit). So it renders unintelligible any principled moral exclusion of non-voluntary and even of involuntary euthanasia. And the second judgement [that the world would be a better place if one's life were intentionally terminated], too, cannot be plausibly defended by reasons such that its range of application would be limited to suicide, assisted suicide and voluntary euthanasia; its sense and its grounds alike extend to include non-voluntary euthanasia. 4

We have seen this logic carried through in the Netherlands where many of the acts of euthanasia are cases of non-voluntary euthanasia, if not involuntary. 5 As the House of Lords recognised there is just no way of preventing the movement down this path.

Even if one does not accept this logic, one must consider the position of the most vulnerable in our society. The New York State Task Force entrusted with considering this issue use even stronger language than the House of Lords:

No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterises the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care. 6

Even people who have no moral objection to euthanasia or assisted suicide in themselves, can still see the strength and wisdom of arguments against legalising assisted suicide.

The United States has some experience of assisted suicide legislation. Their Conference of Catholic Bishops in their document, To Live Each Day with Dignity highlighted some of the problems with it. First of all there is the problem of clinical depression. How is this to be ruled out? Even if there is some examination required, before the script is issued, once the script is in the hands of the patient there is no control regarding the state of mind of the patient when he or she decides to self-administer it. For that matter, there is no control to establish that it was self-administered i.e. that someone else didn't decide to use the drug to kill the patient. With assisted suicide, just as much as with voluntary euthanasia, does one prevent pressure from others leading to a person 'asking' for assistance in dying?

In other words, most, if not all, the arguments and evidence which persuaded politicians that you could not safely legislate for voluntary euthanasia, still apply to assisted suicide. Although the pro assisted suicide advocates put the emphasis on the autonomy of the person wishing to die, the fact is that it still involves a judgement that this is a life 'not worth living', and the doctor must in some way concur with that judgement if he or she is doing to give the script for the desired drug. So the law would create a category of citizen whose life is deemed 'not worthwhile'. Once you create such a category you are sending a message that some people are better off dead, and the criteria for fitting into that category will inevitably be arbitrarily applied. People are put into this category even without exercising choice. In Oregon some health funds will not fund medicine for palliative care, but will fund medication for assisted suicide, and offer this as an option to their clients!

As I said, even people who have no moral objection to euthanasia or assisted suicide in themselves, can still see the strength and wisdom of arguments against legalising assisted suicide.

However, I do believe that we also need to argue the fundamental moral argument as to why assisted suicide is wrong for anyone. The arguments against legalising euthanasia and assisted suicide generally look at the effects that such legalisation will have on vulnerable others who do not really want to be euthanised or assisted to die. And so the pro-euthanasia camp will continually...
seek to build in safeguards to proposed legislation, to convince the legislators that it can be safely quarantined. One of my colleagues suggested that we are actually helping the pro-euthanasia movement by pointing out the lack of protection in proposed legislation. They take our comments on board and set about trying to draft legislation which improves the protections. I think this is one of the reasons the emphasis is shifting to assisted suicide.

So I will briefly consider the moral argument. On the surface, the argument for assisted suicide hinges upon the ‘autonomy argument’, i.e. that a person should be free to choose the manner of his or her dying. However, this argument simply presumes that the exercise of autonomy in this way is not a choice against the intrinsic dignity of the human person. The argument overlooks what is the purpose of our autonomy, our freedom to choose – a purpose which we recognise in other areas in which we limit free choice, but which is studiously ignored in this argument.

Assisted suicide, like euthanasia, is inconsistent with recognising the continuing worth and dignity of the person’s life.

We do not generally accept that the ability to do what one happens to want to do is sufficient self-government in the conduct of one’s life. Someone whose disposition is one of wanton self-indulgence does what he or she happens to want to do, but is not regarded as a mature person nor as exercising free choice for his or her own welfare.

“The capacity for self-government is properly exercised and developed with a view to the flourishing or wellbeing of the person who possesses it, and of the communities to which the person properly belongs in friendship and justice.” (The Linacre Centre, Submission to the Select Committee of the House of Lords on Medical Ethics, June 1993)

“... If our choices seriously undermine in us the capacity to flourish as human beings, and ..., if they aim to damage aspects of this capacity in ourselves or others, there is no reason of moral principle why those choices should be respected.”

Assisted suicide, like euthanasia, is inconsistent with recognising the continuing worth and dignity of the person’s life.

Here we come to the real crux of the problem in our society and in the debate. It is not about ‘autonomy’, but about the recognition of the inherent dignity and worth of the human person. We need to defend the position that ‘dignity’ is inherent in human nature, it is not something that we have or lose depending upon our ability to exercise certain functions. A human being is one that has a radical capacity by virtue of their human nature to exercise those activities which typically reveal our rational nature which sets us apart from other creatures – our capacity to know, to love, to reason, to appreciate beauty. Whether or not we are currently able to exercise those capacities or not, where you have a living human being, there you have a person of deserving our respect.

It is not my place to fully argue that position tonight. I will say though, that only such a position guarantees the equal dignity of all and the just treatment of all. The further one moves away from the recognition of the dignity inherent in each individual by virtue of their human nature, the more arbitrary becomes our criteria for what constitutes respect for another individual – and arbitrariness of this kind is the very opposite of justice.

NOTES
1. By ‘common good’ we mean that ensemble of conditions that enables individual members of the community to pursue their own human flourishing within the community.
2. In every culture known to mankind we find a concept of murder (the intentionally killing of the innocent) distinguished from other forms of ‘justifiable’ killing. (See, e.g. the anthropologist C. Kluckhohn, ‘Ethical Relativity: Sic et Non’ in J. Ladd (ed) Ethical Relativism, Wadsworth, Belmont, 1973, p.89.)
3. HL Paper 21-1 of 1993-94. Extracts published in John Keown (ed) Euthanasia Examined: ethical, clinical and legal perspectives, Cambridge University Press, 1995. It should be noted that several members of this committee were not opposed to voluntary euthanasia in principle, but during the course of the inquiry were convinced that there was no way of legally permitting voluntary euthanasia without undermining the rights of all.
6. Keown, Euthanasia, 188.

Talk given by Dr Raymond Campbell PhD, November 2011
Posted Monday 8 October 2012 on the website of the Queensland Bioethics Centre | http://bne.catholic.net.au/qbc
I was chatting semi-aimlessly with a lawyer friend the other day when the issue of medical power of attorneys and medical directions came up.

My friend, often one to blurt out profundities without notice, said that he objects to patients being asked about whether or not they would want to be resuscitated should something go wrong at the time of being admitted to hospital for surgery. He argued that an imminent surgery and the understandable patient anxiety prior to the operation would make anyone vulnerable to making a poor decision or to being lead to a decision that they might not otherwise make.

I’d never thought of it that way and I’m not entirely convinced by his argument. After all, other than in an emergency, patients hopefully would have had some time to consider their options in consultation with their GP and specialist. It should be the case that, with good quality care and planning, that the options would have been discussed and decisions made prior to the patient attending the hospital. Nevertheless, it seems to both of us that a good protocol for such decision making would be that all of these details should be finalised prior to hospitalisation.

Some euthanasia advocates reject the claim that euthanasia and assisted suicide laws put vulnerable people at risk. Such a claim stands in contrast to a number of studies and reports.

This brings me to consider the whole question of vulnerability and the risk of coercion of patients. In terms of euthanasia and assisted suicide this vulnerability is often expressed in relation to those in our community whom we recognise as vulnerable in general terms. I’m thinking of people living with disabilities, the frail aged etc., in other words, those whom society accepts may need additional supports in their pursuit of acceptance, equality and protection from harm.

And so we recognise, not by data alone, but by commonsense and experience, that there are ‘at risk’ cohorts within our community. Our laws and our behaviour as a society need to be constantly scrutinised, ever asking the question: does this action or law enhance or diminish the respect, protection and lives of those least able in our community?

Some euthanasia advocates reject the claim that euthanasia and assisted suicide laws put vulnerable people at risk. Such a claim stands in sharp contrast to the conclusions reached in reports such as the New York Task Force, the 1998 Tasmanian Inquiry among others and is contraindicated by any number of studies and reports in recent years. In fact, euthanasia advocates such as Dr Nitschke and CEO of the pro-euthanasia group Dignity in Dying UK, Sarah Wooton, both recently acknowledged that...
there are risks inherent to vulnerable people in euthanasia and assisted suicide legislation.

However, it would be a mistake to consider that vulnerability in terms of euthanasia and assisted suicide is only restricted to identifiable cohorts within our community. This would be to ignore the reality that each and every one of us can experience circumstances and events that could conceivably render us vulnerable to negative suggestions and thoughts in respect to the value of our very lives.

A Swiss study published in the *New England Journal of Medicine* in April this year found that people who receive news of a diagnosis of cancer were 12.6 times more likely to commit suicide than people of a similar background who were cancer free. The stress associated with the diagnosis diminished over time, the report noted. Yet, after 12 months, the risk of suicide in this group remained 80 per cent higher than the cancer-free control group.

This confirms a 2005 study of cancer patients which found that the risk to request euthanasia for patients with a depressed mood was 4.1 times higher than that of patients without depressed mood.

And, most recently in May of this year a Spanish research project looking into the reasons behind why patients might develop a ‘wish to hasten death’ concluded that, “The expression of the WTHD in these patients is a response to overwhelming emotional distress and has different meanings, which do not necessarily imply a genuine wish to hasten one’s death.”

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### The question should never be how we propose to kill; rather, the pressing question, always, is how do we learn to care better?

The researchers noted that this result came as something of a surprise to them, but what they actually confirmed is that the common understanding of suicide and requests or expressions of a wish to hasten death as, more often than not, cries for help, understanding and acknowledgement, still holds true.

And, of course, it is not only medical diagnoses or chronic or terminal illness that can trigger vulnerability. June the 15th is World Elder Abuse Awareness day, marking great concern for a modern phenomenon that should concern us all – abuse of the elderly. Elder abuse is the financial, psychological, sexual and/or physical abuse of elder persons. Often perpetrated by a relative, carer or other trusted person upon elderly persons who are frail and/or socially isolated, elder abuse is already being called the ‘crime of the century’.

Elder abuse is significantly under reported. In 2009 the Queensland Elder Abuse Unit estimated the prevalence of EA to between 13,896 and 42,757 older people experienced some form of emotional distress, physical trauma, sexual abuse, financial abuse, social abuse and or neglect in the 2007/08 financial year in that state alone.

It should be a matter of great concern demanding vigilance on the part of all of us as well as our governments that vulnerable people should continue to experience protection, compassion and care; after all, we’re all potentially vulnerable at some point in our lives. The question should never be how we propose to kill; rather, the pressing question, always, is how do we learn to care better?
Why are we talking about euthanasia now? Why do we want to reverse current moral and medical practices at this moment in our history? Reflecting on these questions might help to shed light on the underlying issues in the debate. I can identify two important factors driving the push for euthanasia in Western countries.

The first is the way we understand and construct suffering in the West and how we respond to the fear of suffering. Suffering is often regarded as one of the biggest enemies in Western cultures. It is anathema to the comfortable and affluent lifestyle of most Westerners and to the individualism it fosters. Westerners do not want to lose their autonomy, nor go through excessive pain. In itself, there is nothing wrong with the aversion to losing autonomy or the avoidance of pain, especially excessive or over-bearing pain. Seeking to alleviate pain through positive means is legitimate. Western countries are very good at this alleviation, which is coupled with an admirable concern that all have access to high levels of health care and a dignified death. Avoiding excessive treatments is also legitimate, particularly when the burden of such treatment is too much and will achieve little. Yet, the fixation with personal autonomy and pain-avoidance in Western cultures often seems to border on obsession. This obsessive fear leads to problematic solutions such as euthanasia, in which death is used to cut suffering off.

Living a human life unfortunately involves suffering, not just because we can feel pain but because we know what suffering means. Suffering for humans is not just a mechanism by which we recognise a problem in our bodies or species (through instinct). Suffering is an existential challenge that confronts each of us with the radical freedom that we are given, but also the utter finitude that we are subject to. In other words, we are free but we are limited.

It has been shown that in countries with euthanasia, people are killed without following the proper processes and without their consent.

Suffering highlights the difficulty of this state, leading us to ask, “Why?” Why do I suffer? Why am I limited? Why does freedom sometimes lead to negative outcomes, such as my own pain or the pain of others? We are given the task of trying to make sense of what is often senseless.

The obsessive fear of suffering that pervades the Western worldview seems to indicate that Westerners are losing a sense of what suffering means; and this is because they have lost a sense of what being human means. What do I mean? Those in Western, developed countries have access to the most sophisticated forms of pain relief. Many past and present societies (including...
those in the developing world) have much greater reason to fear pain and ineffective treatment, due to the lack of medical resources and expertise. Yet, in most of these countries, euthanasia is not even countenanced. These countries can, at least to some degree, cope with pain, culturally, existentially and metaphysically.

The reason Westerners have trouble making sense of suffering is that they don’t have these same cultural and existential resources for making sense of life, suffering and death. Any worldview or culture must make sense of the basic questions of life: Why are we here? What is the purpose of life? Why are there evil and suffering? The Western postmodern, consumerist and capitalist view works very well in some areas of life, such as motivating people to work and seek material gain. However, it also has severe limitations, especially around dealing with suffering. On the one hand, a dominant strand of Western culture denies any universal truth or transcendence, particularly in regards to God, love and eternal life, which may help to make sense of suffering; while on the other hand, Western culture is deeply influenced by capitalist individualism that privileges materialism. For most Westerners, ultimate value lies in material goods and affluence, yet material affluence in capitalism is unstable and provides little solace when one is faced with suffering, disaster or death.

Because Westerners can’t adequately make sense of life and suffering through capitalist materialism, their fears become misplaced. Suffering is excessively feared because people do not know how to cope with it, make sense of it and even positively respond to it. Thus, instead of seeing suffering as an evil that can be combated by our best resources of love, solidarity and fortitude, Western culture seeks to control it by cleansing it from our lives. Yet, as past actions indicate (particularly in the 20th century), as humans try to cleanse some part of their humanity because they see it as a problem (think of the century’s genocides or the eugenics movement), they make the problem worse. The same goes for suffering: the more a culture tries to run from it or take excessive control of it, the worse it will become.

This is shown in countries that already have euthanasia, such as the Netherlands: the reasons for euthanasia are constantly expanding to go beyond relieving excessive pain to other reasons, such as to euthanise those who don’t want to live beyond a certain age or the mentally ill. This is because death begins to be seen as the answer to pain or a deficient ‘quality of life’ in any form. Once we start on the slippery slope, it is hard to get off. This is because the underlying problem is not excessive pain, but how we deal with it and our fear of suffering.

Our Western fear of suffering has gone so far that it is argued that ending a life in pain is the truly ‘loving’ act. This is understandable, especially when a loved is in extreme pain. Yet, for the Western tradition, one important way of knowing what love is and where its limits lie has involved referring to the commandment “thou shalt not kill”. This is not just a ‘rule’ to be stubbornly stuck to, but points to an underlying human value – that genuine love cannot involve the killing of an innocent human being. Why? Because love is opposed to death and murder in its nature.

Yet, some argue that suffering takes away our dignity. Nevertheless, we should be careful to distinguish the different forms of dignity that can be discussed in relation to the human person. Firstly, there is the absolute dignity that is inherent to every human life that prevents others from controlling or killing us. Secondly, there is the subjective sense of dignity which we feel about ourselves or others, according to social norms and worldviews. In the case of end-of-life issues, these two different forms are seemingly in conflict: our inherent dignity seems to be in conflict with our subjective and social sense of dignity and compassion. It may be tempting to think that we can protect people’s dignity and take suffering away through death, but this action can result in unforeseen consequences that undermine our inherent dignity and rights. It is very challenging to deal with suffering, but the very basis of freedom and good social relationships relies on the fact that we respect the absolute dignity of each other. Let me explain.

Ordinary human life and relationships do not involve taking control of the whole of the other’s life. In murder and torture we take complete control because we can take away the whole of the person’s life. This kind of control goes against our moral integrity and against the freedom of the other (even if they ask us to do it). Human freedom does not fundamentally lie in ‘what I want’ (whether that is a ‘choice’ to die or not), but in the integrity of my person that cannot and should not fundamentally be controlled, abused or taken away by another.

The integrity (or dignity) of the human person is absolute. We may feel tempted to abrogate the integrity of the other for a seemingly greater good. However, this leads to a ‘slippery slope’ that leaves our integrity and dignity subject to the will and whim of humans where it can be manipulated. It is argued that safeguards can protect against these abuses. Yet, the frequency with which the euthanasia process is abused in those countries that have made it legal – e.g. when people are killed without consent or with forced consent – shows the problematic

Suffering should not be seen as the real human enemy, nor should it be feared out of proportion. Death is the real enemy, and was seen as such in the West until recently.

Yet, some argue that suffering takes away our dignity. Nevertheless, we should be careful to distinguish the different forms of dignity that can be discussed in relation to the human person. Firstly, there is the absolute dignity that is inherent to every human life that prevents others from controlling or killing us. Secondly, there is the subjective sense of dignity which we feel about ourselves or others, according to social norms and worldviews. In the case of end-of-life issues, these two different forms are seemingly in conflict: our inherent dignity seems to be in conflict with our subjective and social sense of dignity and compassion. It may be tempting to think that we can protect people’s dignity and take suffering away through death, but this action can result in unforeseen consequences that undermine our inherent dignity and rights. It is very challenging to deal with suffering, but the very basis of freedom and good social relationships relies on the fact that we respect the absolute dignity of each other. Let me explain.

Ordinary human life and relationships do not involve taking control of the whole of the other’s life. In murder and torture we take complete control because we can take away the whole of the person’s life. This kind of control goes against our moral integrity and against the freedom of the other (even if they ask us to do it). Human freedom does not fundamentally lie in ‘what I want’ (whether that is a ‘choice’ to die or not), but in the integrity of my person that cannot and should not fundamentally be controlled, abused or taken away by another.

The integrity (or dignity) of the human person is absolute. We may feel tempted to abrogate the integrity of the other for a seemingly greater good. However, this leads to a ‘slippery slope’ that leaves our integrity and dignity subject to the will and whim of humans where it can be manipulated. It is argued that safeguards can protect against these abuses. Yet, the frequency with which the euthanasia process is abused in those countries that have made it legal – e.g. when people are killed without consent or with forced consent – shows the problematic
nature of dealing in death and not respecting the absolute dignity of the human person. It is a symptom that human societies cannot control death because it is an inherently destructive process. When we devalue the life of another, it opens the possibility for selfish desires to manipulate processes, no matter how many rules are in place. Rules need people to follow them, through the support of a culture – that includes positive ethical virtues, practices and beliefs.

It is the absoluteness of our dignity that undergirds human rights and freedom, because it means our rights cannot be changed or manipulated by human intentions or will. In contrast, euthanasia means that the dignity of human life is not absolute; our inherent dignity can be taken away by the way I feel in a particular moment or by the way others regard my condition. ‘Dying with dignity’ really involves having my moral integrity, and the integrity of others, respected – not just in the choices we make, but in the life we live that should not be manipulated or controlled by others. Our culture should support us to live according to both senses of dignity – our inherent dignity and our subjective sense of it – by living life as positively and lovingly as possible. A certain sense of our subjective dignity should not be privileged at the expense of our inherent dignity, as our absolute dignity is the basis on which mutual respect and relationships are built. Instead, our subjective dignity should be consistent with and allow us to know better our inherent dignity, which is ultimately about fostering free and loving lives.

Moreover, subjective dignity is more difficult to define than our inherent dignity; and it can vary according to the circumstances of pain, love and hope that are present in one’s life. This is shown by the way in which we usually contemplate the option of suicide and murder in our darkest moments when we believe there are no other options or that there is no meaning left in life. We are naturally relieved when we don’t follow through on these destructive acts because we can usually find other options and sources for hope. For example, many people legally acquire deadly drugs in Oregon (USA) to kill themselves but do not follow through with them. There are various reasons for this, but for some, life changes, ways are found to deal with pain, and new hopes are found, particularly with the help of others. The extraordinary thing about human life is that it can have a value in many different circumstances, particularly when hope and faith in goodness is fostered. When we have hope, we are given motivation to live.

Many euthanasia advocates live under the impression that they should be given what they want, without respecting the fact that in getting what they want they are making others participate in their act.

In making this statement, I acknowledge the deeply difficult issues that are faced when someone is dying and is in extreme pain and difficulty. I have seen them. I support the provision of all appropriate measures of care and relief. In providing appropriate and loving care, I have seen the capacities of the human spirit to confront the end-of-life with humble courage that inspires the care and solidarity of others. These capacities make sense of suffering as a time for us to band together and positively struggle together. For example, when my grandmother slowly approached her death at 98 years of age, she was in great pain for months. However, her last days and weeks were important moments all of us as a family to deepen our relationships, together with her. Her weakest moments were in some ways her greatest: they showed who she was (as she accepted her limits, persevered for others and offered her life in faith); and they revealed who we were in our solidarity with her. Confronting suffering in this way can lead to solidarity: to the unity of self-giving love that builds communion.

In these moments, we can see the real dimensions of human dignity in the way that we care and love each other in our vulnerability. Love in the most difficult circumstances is where the meaning of life is really shown. Love as the highest value of life is opposed to the destruction and control that euthanasia and murder enact. Part of this involves acceptance of our human condition – it involves accepting our limits and not seeking to take control of life. It also means receiving help from others which can give meaning to the experience of dying and suffering.

The second important factor driving the push for
euthanasia is radical individualism. A common catchphrase in the euthanasia debate is that “I should have the freedom to choose to end my own life when I wish.” In one sense, each of us has this freedom at any moment in our life (with access to the right means). Yet, there are two glaring problems with this statement. Firstly, the astounding position that a society would legitimate suicide under the guise of freedom shows confusion about human dignity and our moral limits. Secondly, any individual freedom usually requires a social foundation to make it possible. It is one of the paradoxes of life that we have forgotten in the West. In other words, individual freedoms and rights don’t materialise out of our supposedly ‘autonomous’ lives, but are made possible by us agreeing to live together under certain terms and respecting each other on these terms.

The idea that some people would compel the rest of us to legitimise or facilitate their death is presumptuous in itself, but it is also deeply naïve. Many euthanasia advocates live under the impression that they should be given what they want, without respecting the fact that in getting what they want they are making others participate in their act. It is not as easy as just being given a ‘choice’. There are a new set of procedures and structures that would need to be created for this euthanasia industry, with drug manufacturers, hospitals, doctors, nurses, lawyers, etc. Many people would have to be involved in this choice. Is this a fair thing to ask, particularly in the light of the fact that many people do not want to participate in a system that condones or facilitates death?

Moreover, such a system brings about consequences that will be borne by those remaining alive, not those dead. Those consequences include changes to the health and palliative care system (which can become neglected in favour of euthanasia), the doctor-patient relationship (e.g. patients fear that their doctor may prescribe euthanasia, rather than a life-saving treatment) and the legal system (that must now deal in death). Other changes include the affects of the many abuses and injustices of the euthanasia system that have been shown to result, and the underlying changes to how life, death and hope are constructed in society, particularly for elderly people who often feel pressured into euthanasia and lack support. This ‘slippery slope’ of changes shows that using negative or destructive means is not the way to achieve a good end. There are always unintended consequences and abuses when using evil or destructive means, which particularly hurt the vulnerable.

At its foundation, this second factor is linked to the first. The fear of suffering is a symptom of contemporary Western identity: that it is built on an individualism that promotes absolute self-sufficiency and avoids any dependence on others. This self-enclosed identity is threatened by suffering as it causes us to seek help from and become dependent on others. The inadequacy of radical individualism leaves an existential void about the questions of life, particularly suffering, and tries to fill this void with an unrealistic notion of human freedom and choice.

Losing our autonomy in suffering should not be seen as the real human enemy, nor should it be feared out of proportion. Death is the real enemy, and was seen as such in the West until recently. Death in itself was seen as essentially opposed to life, as cutting life off, and as abrogating the value of life; yet death was not something to be feared as there was seen to be a greater power in life beyond death. Imposing death on innocent people came to be regarded as beyond our moral limits because it involved participating in destruction and taking absolute control of another’s life. One of the most important consequences of thinking we can wield death is that it devalues life in general by undermining our inherent dignity.

We should do our utmost to alleviate suffering but we should not compromise our moral integrity and dignity in doing so.

Therefore, euthanasia is not as simple a solution as it may seem, despite the marketing cries and individualistic demands for choice. There are deep issues at stake that are central to who we are as humans and how we respect human dignity and freedom. Human life is usually more complex and paradoxical than the current euthanasia debate presents. We should do our utmost to alleviate suffering but we should not compromise our moral integrity and dignity in doing so. If we do, we lose the very foundation of meaning that makes life worth living. Thus, we must rise to the complexity and paradox of life, or risk losing our personal and collective freedoms and the positive meanings of life that we can discover in that freedom.

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INTRODUCTION

Catholics face a special challenge in Australia today—to explain the unique dignity of human life.

Our wonderful and positive Christian teachings outline:

➤ Why the Church works consistently to alleviate suffering
➤ Why the Church provides fifty-five per cent of the palliative care in Australia for the dying, and
➤ Why Catholic hospitals work hard so that those who are dying do so in peace and dignity, without unnecessary suffering.

The unique status of every human being explains why pro-lifers do not support mercy killing, sometimes called euthanasia. We might shoot a dying dog, but no human, no matter how old or sick, is just an animal. It is wrong to kill innocent human life.

Times are changing in Australian society. Opinions are shifting. While the foundations for decency, tolerance, democracy and basic justice are generally firm, we do find considerable confusion and blind spots; for example, on abortion and human cloning. We are all influenced by the secular world view dominant in our media and culture.

Young people are encouraged to ignore faith, tradition and parents and decide for themselves. “Everything depends on the particular situation,” and “morals need to move with the times” are constant refrains.

Many young Australians are moral relativists at least in matters of sexuality and questions of life and death. Therefore the challenge for Catholics, especially Catholic doctors and nurses, as well as parents, teachers and priests, is to throw light on this confusion.

Is the easiest way out the best way? Why not kill a dying person who asks to be put out of his misery? Where is courage and idealism or cowardice and pragmatism?

What are our duties towards the dying?

Our duties can be recognised by reason, arising from our human nature. We recognise moral truths, which cannot be avoided or denied; truths which are embodied in the natural law and confirmed by Christ himself and the Ten Commandments.

You shall not kill. You shall not destroy innocent human life. Every human being has a right to life.

The unique status of every human being explains why pro-lifers do not support mercy killing, sometimes called euthanasia.

WHAT IS EUTHANASIA?

Euthanasia means killing someone. People who support euthanasia do not usually describe it so bluntly. They prefer to emphasise the suffering euthanasia is intended to eliminate, and the freedom to ‘die with dignity.’ Whatever arguments are used, however, euthanasia means the killing of an innocent person, and usually one who is weak and vulnerable because of illness or disability.

Boiling the issue down like this is not being emotive, but simply a way of keeping the crucial issue clearly in sight. You shall not kill. You shall not destroy innocent human life.

Euthanasia broadly takes two forms. In the first a doctor, acting on a patient’s request, gives an injection or medication with the intention of killing the patient. In the second, called physician-assisted suicide, a doctor prescribes a lethal medication for a patient to take when he chooses.

Many people who support euthanasia are thinking of practices which are simply part of good palliative care. It is not euthanasia to discontinue medical treatment or life-support when they have become useless or too burdensome or disproportionate medical treatment, even if death is likely to follow.

When effective pain management requires dosages of medication which may shorten the life of the patient, this is morally permissible because the intention is to alleviate pain, not to end life. Death is not willed, “only foreseen and tolerated as inevitable” (Catechism of the Catholic Church n.2279).

Euthanasia is often described as ‘dying with dignity.’ But nothing can take away our basic dignity as human beings; not even the humiliations and weakness caused by suffering and dying. We continue to exist in God’s image, unlike the animals. Dying with dignity means accepting the human condition and the love and support of others, as we wait for death to come naturally. It is never easy.

Euthanasia actually undermines the human dignity of everyone who is sick, vulnerable, dependent or disadvantaged. They become disposable, burdens, too expensive to keep. It is no surprise that disabled people and Indigenous Australians, who have often suffered because of others denying their human dignity, strongly oppose euthanasia. A recent survey in the UK found seventy per cent of disabled people felt that legalisation of assisted suicide would create pressure for them to “end their lives prematurely.” They recognise that euthanasia is not a right or a freedom. It is a threat.

THE CHRISTIAN APPROACH TO SUFFERING AND DEATH

I am not a medical doctor or a nurse, but as a priest I have cared for people who are dying and their families. The enormous distress caused by terminal illness, great pain and severe disability deeply affect everyone involved.

It is not unusual to feel powerless...
and defeated in the face of such suffering, although pain control is generally very good in Australia. Christian faith is a great help, not as a crutch or as a consoling illusion. Christians believe that the Son of God, who was also Mary’s son, suffered with us and died for us. In this way Christ redeems us. Therefore it is no surprise that the cross (or crucifix) is the best known Christian symbol of redemption through suffering.

Christians fight against suffering as much as anyone and more than most. That is why more than half the palliative care in Australia is provided by Catholic institutions. But our faith also teaches that we can join our suffering to Christ’s and offer it for a good purpose. Suffering need not be useless and can be transformed into spiritual growth. I often tell the tale of the bedridden grandmother who offered her years of suffering to God for her grandchildren. Think how Blessed John Paul II battled on despite his suffering.

In human history Christian care for the sick, especially those who had no one to care for them, was an innovation. The pagan attitude to suffering was to deny, avoid, and eliminate it. The old and the poor were left to fend for themselves, and disabled, sick or unwanted babies were left to die. We assume that caring for the sick, even when it is dangerous or unpleasant, is the natural thing to do. This is largely because Christianity has shaped our culture and consciences so deeply.

Christianity did this through the two commandments of love which Jesus joined together: to love God, and to love our neighbour as ourselves (cf. Mt. 22:34-40). We owe this love to God because God is the creator and lord of life. We receive it from Him, and it is not ours to take from others. The fifth commandment makes it clear: “You Shall Not Kill” (Ex. 20:13).

Jesus revealed God to us as a loving father. He is kind and merciful to us, and we should be kind and merciful to others (Lk. 6:35-36). For this reason Jesus gave us the Golden Rule: “In everything do to others as you would have them do to you” (Mt. 7:12).

When it comes to death and suffering, Christians should follow three essential principles:

➤ Life has special value because it is created by God as a gift to each of us
➤ We are called to do only what is good, and
➤ We are not permitted to do wrong, even if we intend good to come from it.

HOW SHOULD WE HELP THE DYING?

One of our duties to the dying is to ensure that pain is managed effectively, and that any underlying depression or mental illness is identified and treated. We also have to ensure that the dying are not abandoned. We can understand that those who are sick, in pain, depressed or anxious, approaching the end of life and left alone in a hospital, can be tempted to despair. But when pain, depression, and loneliness are responded to effectively the wish to die often recedes.

Visiting the dying, keeping them company, praying with them and for them is a powerful way of letting them know that they are not alone and not unloved. It can be hard work, especially for the young; but for those who are up to the challenge it is a beautiful work of love and service.

Palliative care is a specialist field. As our population ages, communities and governments must provide more money for palliative care to ensure that the terminally ill receive the very best care, particularly in controlling pain and ensuring quality of life. If euthanasia is permitted hospitals, insurers and governments will be strongly tempted to see it as a cheaper option and reduce funding and cover for palliative care.

I hope and pray that many young Catholics, aware of the importance of defending human life, will become loving, competent pro-life doctors and nurses.

CONCLUSION

One important part of the Catholic task today, which we share with clear-headed humanists and humanitarians, is to explain that just as winter follows autumn legislation to allow voluntary euthanasia or mercy killing would lead to widespread involuntary euthanasia, with many, perhaps a majority of those euthanised being subject to the procedure without their consent and often against their will. This is because it is almost impossible to put legal safeguards in place to stop it becoming involuntary euthanasia.

Studies in the Netherlands have found that more than 50 per cent of Dutch doctors feel free to suggest euthanasia to their patients, with all the pressure this places on those who are sick; and 25 per cent of these doctors admit to ending patients’ lives without their consent. 550 people were euthanised without an explicit request in 2005.

In Belgium, the law permits only doctors to perform mercy killings. Yet nurses perform euthanasia in twelve per cent of cases, and 45 per cent of cases of unrequested assisted deaths.

If permission was ever given to Australian doctors and nurses to kill, those who ‘know better’, who feel a patient is no longer worthy of life because of her suffering, or because he is too expensive to care for, will be empowered to take the law regularly into their own hands without the consent of the victim.

The law has a powerful moral influence and legalising euthanasia would destroy an important human rights protection. Very few countries have legalised euthanasia. We are already started on a slippery slope. Legislating to allow mercy killing would take us over a deep precipice.

The task of young Catholics is to explain to the wider society why it is wrong to kill the sick and the dying; why it is wrong to take innocent human life.

It can be hard to stand up for the truth. But the attacks on human life will become much worse if we don’t.
What must patients do to avoid being killed?

If South Australia and Tasmania legalise medically-assisted suicide, will people fearful of being killed by their doctors be forced to carry ‘sanctuary certificates’ stating they do not want to be euthanased? By Dr Ivan Stratov

Since 1992, I have practised in many sub-specialties including general medicine, oncology, cardiology, endocrinology and nephrology, and I am now a specialist in the area of infectious diseases, with a private practice based at Victoria’s Knox Private Hospital and a public appointment with the Alfred Hospital, primarily in HIV medicine. I’ve worked in Australian capital cities, rural and regional communities, Aboriginal health and abroad with Médecins Sans Frontières (Doctors Without Borders) in war-torn Abkhazia, a small Black Sea nation.

I have treated thousands of patients including those with terminal illnesses such as advanced HIV, cancer, end stage heart, liver or kidney failure, crippling arthritis, chronic gastrointestinal syndromes, severe Parkinson’s disease, stroke, dementia, depression, chronic pain syndromes and plain simple generalised debility from old age.

Among all the patients I have treated, I have only ever had one request for euthanasia, and that was just recently.

The woman concerned was distressed and in pain, having undergone major surgery, complicated by infection. She was at her wits’ end. No doubt her pain was debilitating and very distressing, and perhaps her pain relief was not optimal. Her request for euthanasia, however, was deadly serious and repeated. She even explained that for several decades she had been a supporter of Dying With Dignity, an organisation advocating euthanasia.

As part of my duty of care, I spent time explaining her medical situation and that the pain could be managed and her distress alleviated. Three days later, with her pain relief better managed, she was bright and smiling. Her problems are not fully behind her and she has undergone further surgery but she is continuing to recover.

As stated, this is the only request for euthanasia I have come across. How easy it could have been for a medico to agree to her request and end her life, had medically-assisted suicide been legal. How tragic this could have been for her, her family and friends.

I recently spoke with a cardiology colleague about the issue of euthanasia. He said that he couldn’t think of one single instance of a patient requesting euthanasia. Furthermore, I spoke with two oncology colleagues, neither of whom saw the need for euthanasia.

My father quoted to me the words of Catherine the Great: “It is better that 10 murderers go free than that we execute one innocent man.” We reject capital punishment because history shows that mistakes have been made and innocent people executed. There is no redress following execution. Similarly, there is no redress for a person who has been killed by his doctor following a wrong medical diagnosis or inadequate care.

Australians should never forget the case of Nancy Crick, who committed suicide, ‘supported’ by euthanasia campaigner Dr Philip Nitschke. She had been treated for bowel cancer, yet tellingly she herself said, “I don’t know what I’ve got and they don’t know what I’ve got!”

After her medically-assisted suicide, a post mortem revealed no evidence of cancer. Rather, she appeared to have a twisted bowel and some minor illnesses. The euthanasia zealots then claimed she was not ‘terminally ill but ‘hopelessly’ ill. Euthanasia is no substitute for making a proper medical diagnosis, proper counselling for a suffering patient and family, and comprehensive care – physical, mental and psychological.

Euthanasia is no substitute for making a proper medical diagnosis, proper counselling for a suffering patient and family, and comprehensive care – physical, mental and psychological.

It is too easy for vulnerable people suffering from illness to be preyed upon by ideologues like Philip Nitschke, peddling their ‘peaceful pills’, sugar-coated with assurances like “You’re very brave” or “You have the courage of your convictions”.

Professor Stuart Horner MD, former chairman of the British Medical Association’s medical ethics committee, has argued that euthanasia undermines the basis of law and public morality. He points out that euthanasia requests are often associated with depression and apprehension and are used by patients to assess their worth and value rather than as direct requests to have their lives terminated.

Furthermore, euthanasia undermines the proper financing of geriatric and palliative care. It fundamentally undermines trust between patients (who “don’t want to be a burden”) and their families and healthcare professionals.

Most importantly, Professor Horner says that it’s impossible to put adequate ‘safeguards’ in place so as to limit euthanasia to those suffering terminal, incurable illnesses. ‘Safeguard’ clauses have not worked in Holland where 20 per cent of euthanasia patients are being killed without their consent. Can we countenance the scenario reported from Holland where people are terrified of going to hospital for fear of being euthanased? Some feel they need to carry ‘sanctuary certificates’ stating that they want to die naturally and not by medical euthanasia.

Is this the level of distrust that caring Australians want to permit to develop between patients and doctors?

We need caring, not killing!

Dr Ivan Stratov, MBBS, FRACP, PhD, is a phthisiologist (specialist in infectious diseases) who works at both Victoria’s Knox Private Hospital and the Alfred Hospital. He has worked abroad with Médecins Sans Frontières.

The criminal law in Australia holds that the intentional taking of human life is a major criminal offence. This accords with the United Nations Universal Declaration of Human Rights, to which Australia is a signatory, which declares that the right to the integrity of every person’s life is equal, inherent, inviolable, inalienable and should be protected by law.

Since the intentional taking of human life is the specific aim of every euthanasia law, such a law would be unique in the following critically important ways:

➤ It would intend to subvert the existing law
➤ It would fail to respect the principle that all are equal before the law
➤ It would fail to respect the principle that all human lives have equal value, and
➤ It would attempt to gain legal recognition for the concept of life not worth living.

This would present an impossible task, if honesty were to prevail. It would have to rely on such things as asserted but non-existent human rights, shades of deceit, inexact definitions and words or clauses allowing loose interpretations, rather than objectivity and precision.

The push for legalised medically-assisted death in Australia has now increased to the point where bills are before several state parliaments and another is before the Commonwealth parliament to reverse the previous overturning of the Northern Territory legislation. I have analysed most of the previous failed bills and noted their weaknesses.

Rather than debate the pros and cons of the social role of euthanasia, I believe that MPs, who have sole responsibility for making safe laws, should direct their attention to ensuring that draft euthanasia bills cannot imperil the lives of innocent people who do not wish to die.

It is evident that the authors of those bills have not read any of the extensive literature on this subject because they invariably include, as so-called safeguards, provisions which are known not to work in practice. A common feature of those who advocate euthanasia bills is their touching faith that certain things will happen, just because the draft prescribes them. If that were true, no crime would ever be committed because all crime is currently forbidden by some law.

Definitions are often vague or at odds with ordinary meanings. For example, in place of ‘terminal illness’ one may find ‘incurable illness’. Many illnesses are literally incurable but do not necessarily cause death or shorten life. Pain and suffering are both highly subjective experiences; neither can be measured or compared between persons, while suffering is often due to social causes rather than medical.

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In 1958, Yale Kamisar, an American professor of law in this field, wrote a seminal paper in which he listed these basic difficulties: ensuring that the person’s choice was free and adequately informed; physician error or abuse; difficult relationships between patients and their families and between doctors and their patients; difficulty in quarantining voluntary euthanasia from non-voluntary; and risks resulting from this overt breach of the traditional universal law protecting all innocent human life.

All these problems still exist and others have been added, such as the critical role of depression in decision-making and the evolution in the moral basis for requesting death from the relief of severe suffering in the terminally ill to reliance on respect for personal autonomy. Some of these will be discussed below.

Definitions are often vague or at odds with ordinary meanings. For example, in place of ‘terminal illness’ one may find ‘incurable illness’. Many illnesses are literally incurable but do not necessarily cause death or shorten life. Pain and suffering are both highly subjective experiences; neither can be measured or compared between persons, while suffering is often due to social causes rather than medical.

According to the drafts, both have to be simply accepted as the person describes them, even when this may raise serious doubt. And, as most now allow, if the symptoms are said to
make life ‘intolerable’, even though it is recognised that what one person finds intolerable others can bear, that claim has only to be made to be incontestable. The situation then will have become virtually one of death on demand.

All bills require the doctor to be ‘satisfied’ that the patient’s request was freely made, though no one could ever know with certainty about coercion from sources of which he was totally unaware. But would coercion be likely? Brian Burdekin, a former Human Rights Commissioner, reported that in his experience, “The most vulnerable were the most likely to be abused and the most likely to be coerced.” Subtle degrees of coercion would be almost impossible to detect.

If a well person asks for death he will be referred for counselling. If a sick person asks, he is as likely to be supported in his “exercise of personal autonomy”. And what of autonomy in the presence of severe illness, especially terminal illness, with its frequent association with depression and unrelieved pain, which powerfully hinder careful evaluation of issues?

More importantly, no matter what the patient decides, in every case it will be the doctor’s decision that determines whether euthanasia actually proceeds. Leon Kass, a lawyer and prolific author in this area, wrote that, in view of the totality of the impediments to clear reasoning in such patients, “the ideal of rational autonomy, so beloved of bioethicists and legal theorists, rarely obtains in actual medical practice”.

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**Euthanasia draft bills require doctors to inform patients about the medical details of their illness and future alternatives.**

Doctors are experienced in persuading patients to follow their legitimate advice concerning treatment options, to the point where some have been heard to say, “I can get my patients to do anything I want.” Their power, relative to that of the patient, is large even when there is no intention to manipulate. Euthanasia draft bills require doctors to inform patients about the medical details of their illness and future alternatives. Since such discussions will usually occur in private, one could never know whether such information was accurate, adequate, non-coercive and impartial. If the doctor’s personal view was that euthanasia was appropriate for a patient, we may be sure some would not be deterred from advocating it.

A lot of publicity has lately been given to the fact that some 85 per cent of respondents to opinion polls favour legalised euthanasia. This refers to the Morgan poll which has been using this question for many years: “If a hopelessly ill patient in great pain with absolutely no chance of recovering asks for a lethal dose, so as not to wake again, should the doctor be allowed to give the lethal dose or not?”

It is not hard to see why many respondents, whose understanding of the complex matter of euthanasia is unknown, might agree to such an emotionally charged question. Given that repeated polls have shown that most Australian doctors have not received adequate training in palliative care, and sometimes none at all, should anyone be surprised that too often pain is poorly managed?

Against that background, the poll question may be truthfully reworded, “If a doctor is so negligent as to leave his patient in pain, severe enough to drive him to ask to be killed, should the doctor be able to compound his negligence by killing the patient, instead of seeking expert help?”

The community would be appalled to know how few doctors who must care for dying patients are able to deal with severe pain effectively. The only remedy for this situation will be to introduce mandatory levels of competence in palliative care training in all medical schools. In the meantime, legalising euthanasia will lead inevitably to many needless deaths. Australia has about half the palliative care specialists it needs, all of whom are in cities or big towns.

Too often, draft bills for euthanasia only require the doctor to obtain expert psychiatric advice if he ‘suspects’ the patient is ‘not of sound mind’, that is, has impairment of competence, which is not the key issue. The literature of psychiatry contains abundant evidence that the sustained wish to die is associated, in a large number of the seriously ill, with depression, which alters mood and inhibits the ability to reason coherently.

Not to require consultation by a psychiatrist experienced in the treatment of dying patients whenever a sustained wish to die is encountered, is a negligent omission, especially as
such depression is often difficult to diagnose. A published retrospective review of the Northern Territory legislation in its short life showed that relevant psychiatric evidence had been withheld and treatable depression was missed in four of the seven patients whose lives were taken under its provisions. The demoralising combination of depression or despair, anxiety and fear associated with a desire to die, can usually be treated with a mix of empathy, psychotherapy and medication.

The usual superficial approach to this problem is in stark contrast to the following advice from expert psychiatrists: “No request for hastened death can be understood without first attempting to understand the psychological landscape within which the request arises.” One advised, “Never kill yourself when you are suicidal – you are not yourself then.”

Accordingly, it has been suggested that the need for better training in the detection of profound psychological disturbance in these patients is as great as that for the relief of severe pain. Even in the Netherlands, there is awareness of past failings, as the former health minister from 1994 to 2002, Mrs Borst-Eilers, commented in 2009, “The government’s move [to legalise euthanasia] was a mistake, we should have first focused on palliative care.”

Wherever voluntary euthanasia is practised, legally or not, non-voluntary is also found, including in Australia. Many find this difficult to credit because, whatever their failings, doctors surely would not take life without any request. In fact, they do it because it seems logical.

Once euthanasia for patients who are suffering and ask to be killed is regarded as providing them with a benefit, it will appear, at least to some, that it would be wrong to withhold that benefit from others who suffer as much, but who, for some reason, cannot ask. In their eyes, this would be a matter of compassion. Because the same rationale can be the justification for euthanasia for both groups, the extension of one to the other must be regarded as inevitable and so will be uncontrollable. The Dutch have long since given up trying to prevent non-voluntary euthanasia.

Bills require the doctor to notify the coroner, following euthanasia. Since he will be its sole author, the chief actor and the sole survivor of the event, what chance is there that the doctor will include anything he would not wish the coroner to know?

Some may have found the earlier reference to deceit too strong, but it was not. At length, the draft bill must somehow directly confront the present law which outlaws euthanasia. So, the doctor is required by the bills to certify the death as due to the underlying illness, that is, to lie (though falsifying a death certificate is currently a punishable offence), and the death is not to be regarded, for the purposes of the Act, as any form of homicide, even though it was unquestionably homicide. Truth must yield to weasel words for these bills to succeed.

After euthanasia, the doctor may not be subject to any civil or criminal action, nor to any penalty or loss of privilege by any professional body. With only a few exceptions, medical associations throughout the world hold that euthanasia is forbidden to doctors because it is unethical, that is, morally wrong. Australian state governments establish boards and tribunals to regulate medical practice and they all regard medical life-taking as deserving of deregistration because those doctors are no longer fit to practise, on ethical grounds.

These clauses in the bills are included without the consent or authority of the regulators, who regard them as necessary to protect patients against attacks on their lives, in recognition of their genuine human rights. Just now, when it is being more widely recognised that there is a need for more emphasis on ethics in many areas of moral significance, the supporters of euthanasia want to dispense with them altogether. It may be wondered what benefits the community can expect to gain from having unethical doctors.

When all euthanasia draft bills so far put before state parliaments over many years are reviewed, it can be observed that they go to extreme lengths to shield the doctor from the effects of current law, no matter what he or she may have done negligently or by omission, while including many opportunities for endangering the lives of patients who did not want their life ended.

In justice, it is the vulnerable who need protection, not the powerful. This danger is exactly what all the large committees of inquiry into the consequences of legalising euthanasia have predicted in their published reports, even those which included some members who were in favour of euthanasia. No other reasoned conclusion was available to them after extensive oral and written evidence had been taken from a wide range of community and professional sources. Every law to permit euthanasia will be inherently and unavoidably unsafe.

Brian Pollard is a retired anaesthetist and palliative care physician, who founded and directed the first full-time palliative care service in a teaching hospital in Sydney at Concord Hospital in 1982 and directed it for 5 years. He is author of ‘The Challenge of Euthanasia’ (Little Hills Press, 1994).
Killing terminally ill people is an appealing concept until you look at the empirical data on where it takes society. That’s why the community should be alarmed by Julia Gillard’s support for a conscience vote on a Greens bill enabling the territories to pass laws permitting active euthanasia, a move that would inevitably lead to death tourism to the territories.

We rightly are moved by the requests of some terminally ill people to hasten their death. The minimisation of pain and suffering ought to be one of the main priorities of a civilised society. Moreover, we strongly value the notion of personal liberty and, from the perspective of the parties directly involved in euthanasia (the patient and health worker), the practice is not inherently objectionable. In the case of clear-minded, rational people it will advance their autonomy and sometimes relieve them of considerable pain.

These reasons underpin the euthanasia catchcry of the ‘right to die’. On the surface this sentiment is powerful. This stems largely from the fact we are drawn to rights claims. They are individualising notions and promise to provide us with a sphere of protection from the unwarranted demands of others.

Rights appeal to those of us who have a “me, me, me” approach to moral issues. But buried only slightly beneath such an approach is the inescapable reality that people live in communities; communities are the sum of a number of individuals and the actions of one person (exercising their rights) can have an (often negative) effect on the interests of others.

Thus, in assessing the moral status of any act, it is necessary to look beyond the rights of those immediately affected. There is no moral theory that allows people to exercise their rights in complete disregard of their potential effects on others. It is at this point that the arguments in favour of euthanasia lose their lustre.

The risks of legalising euthanasia do not outweigh the potential benefits. There are two principal adverse side effects of legalising euthanasia.

First, legalising voluntary euthanasia carries the risk that health professionals will commit acts of non-voluntary euthanasia. This perhaps can be addressed by stringent safeguards. The empirical evidence, however, suggests otherwise. One of the few nations where euthanasia is legal is the Netherlands. This is also the nation where the
practice is most widespread. Two wide-ranging studies in the 1990s revealed alarming levels of abuse in relation to end-of-life decisions. Each of the studies showed that in a climate where voluntary euthanasia is condoned, abuse is prevalent. There were about 1,000 instances of non-voluntary euthanasia (that is, where death was caused without the patient’s consent) in each study, and in the first study 27 per cent of doctors admitted to terminating a patient’s life without their request.

Why did this happen? This involves some speculation. However, what is clear is that it is not because of a general insensitivity or callousness among the Dutch towards issues of life and death. On any measure, the Dutch are compassionate, inclusive and caring; in fact, they donate more than twice as much as Australians to the developing world.

Perhaps Britain’s House of Lords select committee on medical ethics, in its report examining the issue of euthanasia, identified the reason for the widespread abuse: “Issues of life and death do not lend themselves to clear definition, and without that it would be impossible to ensure that all acts of voluntary euthanasia were truly voluntary, and that liberalisation of the law was not abused.”

The final, related, argument against euthanasia is that legalisation carries the risk that it will foster or instil the notion that some lives (namely, those of the terminally or gravely ill) are less valuable than others. This sets an undesirable precedent.

Society does not regard deliberate killing as a solution to any (other) personal problems. We do not kill the miserable, depressed or evil.

Followed to its logical conclusion, it would leave the door ajar for similar arguments to be made in relation to all people whose capacity to flourish is for some reason (physical, mental or social) gravely impaired.

There is no principled basis for distinguishing between qualitative and quantitative impairments. If reduced life expectancy is seen as a basis for less value being attached to life, then why should the same not apply to other handicaps or disadvantages?

Society does not regard deliberate killing as a solution to any (other) personal problems. We do not kill the miserable, depressed or evil.

This is because of the supreme value placed on all human life. Problems are not cured by killing people. So it should be in the case of euthanasia.

Perhaps adequate safeguards could be implemented to prevent voluntary euthanasia leading to non-voluntary euthanasia, and perhaps we could be adequately conditioned into accepting that deliberate killing in one context does not implicitly cheapen the value of all (or some other) human life. However, we should tread carefully in condoning practices that suggest some lives are not as valuable as others.

This approach will seem insensitive to those desperately seeking a quiet and peaceful exit. It is an unfortunate aspect of morality that there are times when each of us will have their interest set back to promote or maintain the common good. This is, however, an indispensable part of living in a community.

We need to entrench a culture of life, not erode it. This will enhance all our lives, as indeed it enhances the existence of those whose lives are tragically cut short.

Yet we cannot ignore the pleas of those in pain. The compassionate way to address calls for euthanasia is through an increased commitment to the dying. In many cases this means better pain and depression management.

People contemplating euthanasia should not be encouraged to do so. They should be told that their life continues to have immense meaning and it would be a tragedy if it were to be deliberately cut short.

Mirko Bagaric is a professor at Deakin University, and the author of ‘Euthanasia, Morality and the Law’ (Peter Lang Publishing).

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Opinions in favour of euthanasia

EUTHANASIA: THE MEDICAL DIVIDE

The political debate is heating up, but is the medical profession in favour of legalised euthanasia? Jane Lyons from The Medical Observer reports

When Don Flounders and his wife, Iris, entered a Mexican pharmacy in 2008, it was Valentine’s Day and they considered their purchase of Nembutal just another act of love in their 60 years together.

On the evening of 28 April this year, Don, 81, terminally ill with mesothelioma, and Iris, 88, took the Nembutal. They were found dead the next day, holding hands.

A video, later posted at their request on YouTube, captured their last thoughts as they spoke of their decision to end their lives.

Originally from London, the Flounders and their two children had made the Victorian town of Warragul their home.

In 2007 Don was diagnosed with mesothelioma, and the following year, with the help of euthanasia advocate Dr Philip Nitschke, he and his wife travelled to Mexico to purchase the barbiturate commonly used to euthanise animals.

When we got the drugs, I thought I might not want to live on without Don. Three years on, my thinking is the same. We decided this together,” Iris, who had no reported terminal illness, told the camera.

“I knew that I would want to have the choice at the end as to how and when I die,” said Don.

“I have reached the point where my quality of life is dreadful. I am dependent on Iris and my world has shrunk to this small bedroom. This is no life.”

The couple also said they resent the fact they had to travel halfway round the world to have the choice of a peaceful death.

They hoped their video would help force a change in Australian laws, preventing prosecution of those who attend or assist such a suicide.

Recent court cases have highlighted the very real threat of prosecution and, with public support for voluntary euthanasia polling at 75% to 85% and attempts by state Greens to legalise it, the euthanasia debate is again in the political and media spotlight.

In May, a NSW Supreme Court judge ruled in a retrial of a woman sentenced to manslaughter for assisted suicide that she would serve no further jail time.

Shirley Justins, 62, had already served a 22-month periodic detention sentence after she had placed an open bottle of Nembutal within the reach of her late partner, Graeme Wylie, 71, who had Alzheimer’s disease.

The manslaughter charge was quashed last November and she pleaded guilty to aiding and abetting...
a suicide in the retrial.
On leaving the court, her only comment to the waiting media was: “It is a relief.”
For the medical profession, the euthanasia question sits within a wider debate about end-of-life care. Last year a survey of 500 doctors by Exit International found that 60-70% of GPs in Victoria, SA, NSW and WA were in favour of euthanasia laws. AMApresident Dr Steve Hambleton says the organisation recognises the divergent views about euthanasia among the medical community and even within its own ranks, but it does not support the push to legalise it.
“We believe that medical practitioners should not be involved in interventions that have their primary intention of ending the person’s life.”
With technology allowing doctors to keep people alive for longer, the question of choice raised by the euthanasia debate should focus more on the unnecessary prolongation of life, he says.
“We have to give people back the ability to make that decision, but we don’t want to do it at five to midnight; we want to do it much earlier,” he says.
“It may be that we’re pushing people into desperate places.”
Dr Hambleton acknowledges that even with greater control some patients will find themselves in that desperate place where euthanasia is seen as the answer.
“We do hear about the extremes but the reality is that the majority are not going to be in the extremes,” he says.
Dr Scott Blackwell, the president of the Palliative Care Association, agrees. He points to the rate of euthanasia deaths in the Netherlands, arguing that at 2%, they underline the small role of euthanasia in the bigger issue of quality end-of-life care.
“Euthanasia is a common preference but a rare choice,” he says.
“Our experience is that even with those people who ask, the question goes away with good palliative care.”
He is concerned that providing what he calls an easy solution will stop the search for real answers.
“We need to maximise funding of palliative care services in this country, and euthanasia doesn’t change that.”
While the association neither supports nor opposes legislation, Dr Blackwell admits: “In some ways I think let’s legislate it and let it just find its place.”
Dr Roger Hunt, the director of Western Adelaide Palliative Care and an ambassador for advocacy group YourLastRight, believes it’s time for voluntary euthanasia to find that place.

**For the medical profession, the euthanasia question sits within a wider debate about end-of-life care.**

He says too much has been invested in the myth of its incompatibility with palliative care and its ability to undermine good end-of-life care.
“The [euthanasia] debate is in fact a vehicle for promoting palliative care,” Dr Hunt says.
Nor can palliative care manage all suffering and ameliorate the desire for euthanasia, he says.
“We can’t eliminate all suffering no matter how good palliative care becomes ... To expect to eliminate all requests for a hastened demise in people who are dying is setting an impossible task.”
He points to his own surveys of patient requests done at Adelaide’s Daw House Hospice from 1991 to 1993. Out of 323 patients, 35 stated “I wish it would hurry up”, 19 said “could you hurry it up”, and 20 said “please do something now”.
But whatever the views of the medical profession, the political wheels are starting to turn in the euthanasia debate.
The Greens believe that doctors and people such as Ms Justins should not fear the threat of prosecution any longer.
They want Australia to follow in the footsteps of Belgium, the Netherlands and the US states Oregon, Washington and Montana, and enact voluntary euthanasia legislation.

In Tasmania, Premier Lara Giddings has announced that she and Nick McKim, the Greens leader, will introduce a private member’s bill seeking to legalise euthanasia, early next year.
In NSW, Greens MP Cate Faehrmann will do the same within the next 12 months.
In South Australia, Greens MLC Mark Parnell has co-sponsored a bill with the Labor MP Stephanie Key, which provides a legal defence for doctors involved in medically-assisted suicide. It has been defeated in the Legislative Council but is still waiting for a House of Assembly vote. The West Australian euthanasia bill was defeated in September.
But what has perhaps ruffled the most political feathers is the push by federal Greens leader Bob Brown to repeal the legislation preventing territory governments from legalising voluntary euthanasia.
In 1997 the Federal Government overrode the Northern Territory’s Rights of the Terminally Ill Act, the country’s first euthanasia law, only eight months after it was enacted.
And with some doctors already acquiescing to these requests, it’s better to bring it out from under the carpet and make it safe with legislation, says Dr Christopher Ryan, a psychiatrist and honorary associate at the University of Sydney’s Centre for Values, Ethics and the Law in Medicine.
“People worry about it – that’s fair enough ... so you have safeguards in place,” says Dr Ryan, who was instrumental in ensuring the NT euthanasia legislation included a psychiatric review.
It’s not a slippery slope to ‘Nazi Germany’, as opponents would have us believe, he says. “In Oregon, twice as many people get the tablets as actually use them. They didn’t need to because all they needed was the choice.”

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www.medicalobserver.com.au
Voluntary euthanasia is needed as a last resort in palliative and medical care

It is widely acknowledged, including by Palliative Care Australia and the Australian Medical Association, that even the best of palliative care cannot help all patients – between 5-10% find their suffering so unbearable that they persistently request an assisted death. Our palliative and medical care is highly regarded, but it can never be 100% effective.

Palliative care continues to advance under voluntary euthanasia legislation

The paper Ranking of Palliative Care Development in the European Union shows that the Netherlands, Belgium, and Luxembourg, which all have voluntary euthanasia laws, rank highly in palliative care services.

A further report in 2011, Palliative Care Development in Countries with a Euthanasia Law showed palliative care is as well-developed in countries with legal assisted dying as those without. Advancement of palliative care continues after legalisation of assisted dying. Belgium doubled funding to the palliative care sector when introducing its law in 2002. There is abundant evidence that the drive for legal euthanasia can promote development of palliative care. The law was passed together with an act positing the ‘right to palliative care’, and a doubling of its public funding. It was mandatory for each hospital to have a palliative care team, and palliative home care was to be available nationally. The Center to Advance Palliative Care (USA) has also provided a ‘report card’ on the level of access to palliative care in hospitals by state ranking. States with physician-assisted dying laws ranked very highly in the report. Vermont and Montana scored an ‘A’ ranking as the top two performers of all States. Vermont has palliative care programs in 100% of hospitals, with Montana providing programs in 88% of its hospitals. Oregon and Washington both received a ‘B’ ranking, with programs in 72% and 65% of hospitals respectively. Rankings span levels ‘A’ (81% to 100%) and ‘F’ (0% to 20%).

Trust in doctors is maintained with the assurance of voluntary euthanasia legislation

We put our trust in doctors throughout our lives, and the final trust for many is the assurance that their doctor will not abandon them if all treatments fail.

Kimsma (2010) states that:
A request for euthanasia changes not only the doctor-patient relationship, but also the relationships between patients and their families and friends. This change is a deepening and strengthening of the emotional commitments and relations.

The 2008 European Values Survey reported that where voluntary euthanasia is a legal option, public confidence in the healthcare system is well above the European average of 59%. In the Netherlands it stands at [70%] and Belgium [91%]. In fact, of the 47 countries surveyed, Belgium was second only to Iceland.

In 2008 the GFK Group, the fourth largest market research organisation worldwide, reported that 88% of respondents in Belgium and 91% in the Netherlands trust their doctors.

Voluntary euthanasia laws reduce the incidence of non-voluntary euthanasia

The incidence of non-voluntary euthanasia has not increased since the legalisation of euthanasia in Belgium. On the contrary, the rate dropped from 3.2% in 1998 to 1.8% in 2007. In the Netherlands, the rate dropped slightly after legalisation, from 0.7% to 0.4%. Non-voluntary euthanasia is not a practice confined to countries where voluntary euthanasia is legal. Surveys have compared the incidence of medical end-of-life decisions in Australia with those in the Netherlands and Flanders, Belgium. The surveys were conducted when euthanasia was a legal possibility in the Netherlands but prohibited in Australia and Flanders. Australia had a rate of ending...
Voluntary euthanasia
laws are working responsibly

The Journal of Medical Ethics states: In Oregon USA and Netherlands, where assisted dying is already legal, there is no current evidence for the claim that legalised PAS or euthanasia will have disproportionate impact on patients in vulnerable groups. Those who received physician-assisted dying in the jurisdictions studied appeared to enjoy comparative social, economic, educational, professional and other privileges.12

Conversely the current law prohibiting choice for voluntary euthanasia does make those with irremediable suffering vulnerable to pre-emptive and possibly ill-informed suicide. This is by attempting to escape that suffering by the only means possible – self deliverance. A permissive law addresses this by giving peace of mind to those suffering: actually working to extend their lives. See graph at www.oregon.gov/DHS/ph/pas/docs/year12.pdf

A request for voluntary euthanasia may be rational

Despite the best medical care, a minority of patients will persistently request help to die as the only means of final relief from irremediable suffering. Palliative Care Australia acknowledges that such requests can be rational.13 An argument that is often put forward against voluntary euthanasia is that it would increase the suicide rate. However, it is more likely to lower it slightly. The number of rational suicides is extremely low, and while it is likely that voluntary euthanasia legislation may increase the number of rational suicides, the overall numbers would remain low. If people understood that they could seek voluntary euthanasia from doctors; and that discussions were not out of bounds, some individuals contemplating non-rational suicide, and those with major depression may speak to their own doctors and be diagnosed and successfully treated.15 A survey in 198716 of 869 Victorian doctors found that 93% believed that a request for voluntary euthanasia could be rational. A survey in 199317 of 1,268 NSW doctors found that 96% concurred, as did a survey in South Australia18 of 298 doctors in which 89% considered that such a request could be rational.

Voluntary euthanasia and the Hippocratic Oath

It is sometimes argued that voluntary euthanasia is against the Hippocratic Oath with the injunction to ‘do no harm’. This oath originated 2,400 years ago and begins by swearing to Apollo and to all the gods and goddesses and states that the doctor will teach his art without fee or stipulation. A critical review of the oath reveals that it is ‘steeped in sexism, secrecy, self-aggrandisement, and sorcery’.19 Few if any medical schools require their students to take the original form of the Oath. Avoiding harm is not always possible, as many medical procedures have side effects, and doctors may need to evaluate harms and benefits before advising a course of action. Although doctors are expert advisors it is the patient who makes the ultimate decision on which treatment, or none, represents the greater benefit and lesser harm. An incurably ill patient with unremitting suffering may decide, after consultation and advice, that a peaceful death is the lesser harm. The UK General Medical Council has revised the oath taken by graduating doctors to reflect good medical practice and duties of a doctor.20

Voluntary euthanasia legislation helps circumvent current abuse of the law

It is the responsibility of lawmakers to craft sound laws that minimise circumvention and hold societal practice accountable to scrutiny. Current laws prohibiting voluntary euthanasia fail on both counts. Eight reputable surveys in Australia since 1987 show that many doctors...
disregard the law and intentionally hasten patients’ deaths with drugs, assist with suicides and accede to requests for voluntary euthanasia.\textsuperscript{14}

**Voluntary euthanasia is an act of merciful clinical care**

Voluntary euthanasia is often referred to as ‘killing’ by those who would deny the right to medical assistance in dying. This is spurious and cynical. Chambers 21st Century Dictionary defines killing as ‘an act of slaying’. Killing implies a violent act against someone’s will, rather than a compassionate response to a patient’s informed request.

**Surveys on voluntary euthanasia law reform use scientific polling and unambiguous questions**

Contrary to the claims of opponents of law reform that polling questions are ambiguous, over the past 15 years approximately 75% of respondents gave an affirmative response to the unambiguous question in Morgan and Newspoll surveys:

> *If a hopelessly ill patient, experiencing unrelievable suffering, with absolutely no chance of recovering, asks for a lethal dose, should a doctor be allowed to give a lethal dose or not?*\textsuperscript{21}

**A right to die imposes no duty on another to assist**

All voluntary euthanasia laws allow conscientious objection, protecting the right of any person to refuse to assist in the administration of the law.

**REFERENCES**

1. 1999 Palliative Care Australia Position Statement.
3. Centeno C, Clark D, Rocafort J, Lynch et al., Task Force on the Development of Palliative Care in Europe, European Association for Palliative Care (EAPC).
4. Palliative Care Development in Countries with a Euthanasia Law, European Association for Palliative Care (EAPC), Kenneth Chambaere, Carlos Centeno, Erick Alejandro Hernandez, Yanna VanWesemael, Francisco Guilt-n-Grima, Luc Deliens, Sheila Payne.
6. Centre to Advance Palliative Care, [www.capc.org/reportcard](http://www.capc.org/reportcard)
8. European Values Study 2008, 4th wave, Integrated Dataset. GESIS Data Archive, Cologne, Germany, ZA4800 Data File Version 1 0 0 (2010-06-30) DOI:10 4232/1 10059 (2010).
14. Dr Chris Ryan, consultant psychiatrist, Westmead Hospital and lecturer Sydney University. Based on a talk given to NSW VES reported in the society newsletter March 2003.

Compiled by the South Australian Voluntary Euthanasia Society – assistance from the office of Hon Mark Parnell is acknowledged.

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There is a great deal of misunderstanding about dying with dignity and physician-assisted dying (PAD). Some misunderstanding is the result of lack of information, while other misunderstanding is the result of deliberate misrepresentation by conservative opponents. These FAQs from Dying with Dignity Victoria answer the most commonly asked questions about PAD, particularly in regard to DWDV’s initiatives for law reform.

DWDV promotes death, right?
Wrong. DWDV promotes the right for a mentally competent, terminally ill adult with intolerable suffering to choose whether to persevere or to ask a doctor for assistance to die peacefully. Current Victorian law denies the sufferer that right to choose, despite the overwhelming majority of Victorians wanting that choice for more than 25 years.

If a terminally ill sufferer wishes to continue living as long as is possible, DWDV completely supports and commends that person’s choice and right for themselves. What is not acceptable is for anyone but the sufferer to determine their course of action.

DWDV absolutely agrees that there should be and is a fundamental right to life. Sufferers must have available to them all reasonable medical treatment they wish to accept. However, equally, if a terminal sufferer wishes assistance to depart a little earlier in order to maintain dignity and avoid horrendous suffering, then DWDV firmly believes that right should exist. Others have no right to force their views on the sufferer.

What are the ‘four principles’?
DWDV’s legislative charter is based on four important principles:
1. A terminally or incurably ill patient with intolerable suffering shall have the right to ask for and receive medical assistance to die with dignity
2. No one shall be compelled to participate or not participate against their will in the carrying out of such a request
3. It shall not be an offense to provide advice regarding such requests
4. Sufficient safeguards shall be in place to prevent abuse of the process.

Do you support doctors ‘killing’ patients?
No. DWDV’s legislative charter specifies that the form of requested assistance given to terminally ill sufferers to die peacefully is to provide an oral dose of medication that the patient may consume voluntarily. This is physician-assisted dying (PAD). In order to maximise safeguards, DWDV’s legislative charter does not embrace the broader approach where a doctor administers a lethal dose to the sufferer by injection. The key intention is to relieve suffering, although hastening of death may also occur.

Why ‘PAD’ and not ‘VE’?
We use the expression physician-assisted dying (PAD) rather than voluntary euthanasia (VE) for several reasons.
1. As soon as you say the word ‘euthanasia’, people immediately forget you said the word ‘voluntary’, assuming that it might extend to, or even promote, involuntary euthanasia. It doesn’t
2. Voluntary euthanasia is commonly perceived as something Person A does to Person B. However, DWDV’s legislative charter stipulates that it is something Person B does for themselves
3. It is common practice in many kinds of situations to ‘ask for volunteers’. This is inappropriate for the dying process and the request to die with medical assistance must be the exclusive will of the patient and in no way solicited by others.

Suicide is an emotive word that is often equated with irrational, regrettable acts. However, this is not the case for the terminally ill.

Why not ‘suicide’?
Suicide is an emotive word that is often equated with irrational, regrettable acts. However, this is not the case for the terminally ill.

A professional study published in the Australian medical literature shows that 93% of doctors believe that a request by a terminally ill patient for assistance to die can be rational.

Rather than ‘punish’ the patient for a rational act, DWDV believes it is more important to recognise the intolerable and unrelievable suffering that caused the patient to make the request. That is compassionate, while ‘blaming’ people without thought for their circumstances is not.
For this reason, DWDV’s draft Bill stipulates that the death certificate is to record the patient’s underlying illness, not suicide, as the cause of death.

**Aren’t doctors coping quite well already?**

No. It is currently an offense to assist anyone to die, regardless of their circumstances, although it is legal to provide medical care in the knowledge that it ‘may’ shorten life – the principle of the ‘double effect’.

A 1997 professional study published in the Australian medical literature showed that nearly 1 in 50 deaths is already physician-assisted dying; but these doctors risk prosecution as the intention to shorten life is illegal, regardless of the patient’s circumstances. The law is opaque, depending on the ability to establish ‘intention’ or not of shortening life.

Another 1997 professional study published in the Australian medical literature found that 45% of physicians did not believe that present arrangements are adequate, 68% believed that physician-assisted dying can be an act of caring, and 45% wished to have the option of physician-assisted dying.

**Should doctors decide who dies?**

No. Nor should relatives. The only person who should decide whether a terminally ill sufferer dies with medical assistance is the sufferer alone. This is what DWDV’s legislative charter specifies. It also means that the sufferer must be mentally competent and well informed to make that decision. If the sufferer is not mentally competent, no decision can be made, except subject to any wishes documented in an advance directive (living will) made previously by the sufferer, or with the advice of the Public Advocate.

**Isn’t palliative care always enough?**

Palliative care is an excellent modern medical practice, and in many cases can provide relief for the terminally ill. However, this is not always the case, which most palliative care specialists would acknowledge. In about 5% of terminal cases, palliative care simply is unable to provide relief from intolerable suffering.

While hardly cheerful, the following are facts:

- A motor neuron disease (MND) sufferer becomes progressively paralysed. Late in the disease, breathing can be seriously hindered. Many MND sufferers fear suffocating to death more than anything else and would prefer to go in a dignified manner whilst being able to say goodbye to loved ones, rather than desperately gasping for breath.
- Asbestosis sufferers not only gasp desperately for breath, but breathing is extremely painful.
- A sufferer with cancer of the spine may have pain so severe that it can only be relieved by terminal sedation (TS).
- For many patients, suffering is not just about pain. Suffering can include other factors such as loss of control of wits, bowels or bladder, or such weakness that they are completely dependent on others for every intimate part of their daily care.
- A 2007 study published in the *Journal of Clinical Oncology* shows that despite the availability of good palliative care, one quarter of late-stage cancer patients experience moderate to severe suffering.

**Aren’t palliative care and PAD incompatible?**

No. Palliative care provides many sufferers with adequate relief from pain, distress and suffering. But for some sufferers, it is unable to and they may suffer terribly unless the doctor is prepared to increase the dosage to a point that will induce coma, which may have the side effect of hastening the patient’s death.

In fact, palliative care specialists already have a term for the process of inducing a profound coma before death: terminal sedation (TS). Some doctors insist that it is the practitioner’s intention (to relieve suffering rather than to cause death) that makes the profound difference. In fact, if the primary intention is to hasten death, the doctor may be charged with murder under current Victorian law.

DWDV firmly believes that a mentally competent...
sufferer deserves the respect to make that decision of time until death for themselves. And indeed, under existing Victorian State law, maximum palliation even if it hastens death may be specifically and legally requested by the sufferer.

**But isn’t knowingly hastening a death morally wrong?**

We each have to determine for ourselves what is right and wrong, especially in life and death situations. But those decisions are ours alone.

As Dr Ronald Dworkin, Professor of Jurisprudence at Oxford University said, “Making someone die in a way that others approve, but the dying person believes a horrifying contradiction of his life, is a devastating, odious form of tyranny.”

**Don’t PAD supporters just want to save the health system money?**

This is a highly offensive claim of conservative opponents; an attempt to shut down the dying with dignity debate with which they are so uncomfortable.

DWDV makes no consideration whatever as to any possible economic impact of the right to choose either way. The only aim is to give terminally ill sufferers the right to full self-determination, a right they currently don’t have.

Suggesting or claiming that DWDV wants people to die faster because it will save the health system money is defamatory and may lead to legal action.

**Wouldn’t PAD be open to abuse?**

No – because of strict and effective safeguards.

When PAD is legal, it is mandatory that there is a formal, safe and secure process in place to prevent its abuse. DWDV’s legislative charter proposes highly effective safeguards, modelled on successful Oregon law. Formal annual reviews of the Oregon law as applied in practice over nine years have clearly demonstrated an absence of abuse.

With such safeguards, claiming that doctors or relatives will force the sufferer to choose to die, are spurious and without foundation.

**Won’t doctors be forced to participate against their own beliefs?**

Definitely not. Under DWDV’s legislative charter, a doctor has the right to decline to act on a sufferer’s request for assistance to die if it is against the doctor’s own beliefs.

The charter also specifies that private medical institutions may also make a ruling that such practices may not be carried out in or using their own services or premises. Ultimately, it’s about choice for everyone.

A sufferer who has specifically made requests for PAD and passed the necessary due safeguard process sees the process as ‘relief and release’, and not in any way ‘killing’.

**Wouldn’t there be an avalanche of deaths?**

The factual evidence shows this is not the case at all. Formal annual reviews of the Oregon laws in practice show clearly that there has been no significant increase in physician-assisted dying at all. These reviews have been conducted for nine years now. DWDV’s legislative charter is modelled on Oregon law.

In fact, many patients (such as Steve Guest) report that a great weight is lifted off them when they have a real choice, and there is no necessity to ‘rush’ into an early death by one means or another. So, choice often prolongs life rather than shortens it.

A real consequence of lack of choice to die in a dignified manner with medical assistance is that some sufferers attempt to take their own lives anyway while they believe they still can, often by violent and undignified means. And they don’t always succeed, ending up in a worse state than ever before. This is a tragic but factual consequence of the lack of legal choice.

**Wouldn’t those with access act hastily?**

This common objection mistakes access with use: that is, it is assumed anyone who is granted access then immediately goes on to use it. This perception is quite wrong. Formal statistics from nine years of operation in Oregon show that only a minority of sufferers actually go through the process to obtain permission for medical assistance to die. One third (34%) of those who receive the prescription actually never use it, showing restraint and careful thought.

What happens in practice is that people who obtain access feel a profound relief at having control back over their end of life, but do not feel compelled in any way to end it right now. It is this control that itself is very good palliative care, and helps relieve some of the very significant (existential) suffering.

Granting of permission to assist actually removes the necessity to act hastily, including taking one’s life by violent means (e.g. jumping in front of a train) because one doesn’t have to ‘take action’ while one is still physically able to move about freely.

This means that objections that highlight Mr or Mrs So-and-so who was given three months to live and was alive and well five years later, are irrelevant. It is only when the patient’s situation becomes truly hopeless and the suffering severe and unremitting that those with access finally decide to use medical assistance to die on their own terms.

**Shouldn’t we allow religious leaders or politicians to decide this moral issue for us?**

If a terminally ill sufferer wishes to seek religious counsel to help make a difficult end of life decision for themselves, DWDV absolutely supports that.
Suffering at the end of life is a very personal experience. Individuals should be free to consult whoever they want to help them make their own choices. However, the view of religious leaders or politicians should not overrule the right of the individual to make their own informed decision.

In addition to this, the 2006 census shows that close to 1 in 5 Australians (16%) have ‘no religion’, so it doesn’t make sense for religious leaders to make decisions for everyone. (To put this in perspective, the number of ‘no religion’ Australians now exceeds the number of Anglican Australians, though not the number of Catholic Australians.)

**Don’t you just use ‘horror stories’ to shock people into agreeing with you?**

This is an offensive claim by conservatives who oppose self-determination. It exposes ignorance at best and a profound lack of compassion at worst. It trivialises the suffering that such individuals have been forced to endure.

All our stories are real stories about real people. We present them as factual evidence as to what actually happens when people are not given a legal choice.

**Isn’t this just the start of a slippery slope?**

The ‘slippery slope’ argument is a scare tactic used by conservative opponents to shut down the dying with dignity debate so that the law continues to conform with their views.

An official review of nine years of Oregon (USA) PAD statistics shows a modest number of people – not an ‘avalanche’ requesting PAD. Fully one third of those who receive a PAD prescription end up not using it. Clearly, restraint is exercised.

DWDV has published a legislative charter in plain English that spells out exact proposals for legislative reform. Nothing more. Nothing less. If it doesn’t appear in the legislative charter, it’s not proposed. And DWDV’s Charter is based on the Oregon law.

Individuals and groups can easily determine the scope of the proposal and decide whether they wish to support it, debate it, or oppose it.

A number of politicians and respected organisations have already endorsed and shown support for DWDV’s legislative charter. You can support it too by signing DWDV’s petition to State Parliament.

**Won’t the depressed and people with disabilities be next?**

Absolutely not. This is an extension of the discredited ‘slippery slope’ argument. DWDV believes firmly that those suffering depression in the absence of a terminal illness with intolerable suffering should be directed to proper psychological care. A choice to die because of intolerable and unrelievable suffering near the end of life can be rational, but a choice to die because of psychological illness alone is not.

Nor are people with disability per se ever intended to be covered by medically-assisted dying laws. DWDV opposes that firmly, and its legislative charter specifically makes these points abundantly clear.

In any case, DWDV’s recommended process stipulates that the decision and action to die with medical assistance is the patient’s alone and not of any third party. This means that involuntary euthanasia is specifically excluded and forbidden.

A choice to die because of intolerable and unrelievable suffering near the end of life can be rational, but a choice to die because of psychological illness alone is not.

**Is it wise to legislate for ‘exceptions’?**

The claim is that terminal suffering that cannot be adequately addressed by palliative care is very rare and therefore at best is not worthy of legislative effort and at worst exceptions are just too ‘tricky’. This is another false argument.

Firstly, it is wrong in law. Much law attempts to legislate the exceptions. Speaking of dying, the average annual murder rate in Australia is approximately 0.002% (or 1 in 50,000). That’s very much the exception to normal behaviour. Yet legislate against it we do, and rightly so.

Terminal illness suffering cannot be adequately palliated to the sufferer’s satisfaction in around 5% of cases, yet we have not legislated for choice in more than 25 years of an overwhelming majority of Victorians wanting it. And because modern medicine is so effective at keeping people alive, around 85% of us will die in hospital of a terminal illness rather than “passing away quickly and peacefully in our sleep” at home. This means that the 5% is growing in absolute numbers of people.

Secondly, it shows a breathtaking lack of compassion for sufferers. The issue is not about the technics of palliation. It’s about the experience and beliefs of the sufferer who, if mentally competent and with sound medical and other advice at hand, deserves the respect of self-determination.

**What about ‘suicide tourism’?**

‘Suicide tourism’ is a highly offensive expression. It completely trivialises the deep and unrelenting suffering experienced by many terminally ill people. To suggest that people go on a ‘happy holiday’ to die, a long way from home, family and friends, lacks insight and compassion.

Nevertheless, DWDV believes that it would be inappropriate for the State of Victoria to support PAD for those whose only purpose in visiting is to die. PAD would be available only to residents of Victoria.

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www.dwdv.org.au
A challenge to our leaders – why don’t we legalise euthanasia?

We can choose so many of our life experiences, but it seems we can have no say in whether we die in pain or at peace. Today we consider why we don’t have a policy on physician-assisted suicide. Richard Denniss discusses

It’s often said that the only certain things in life are death and taxes. In reality, of course, if you’re willing to pay lawyers and accountants enough, you might be able to avoid taxes. But no matter how much you spend on doctors, the best you can do is prolong your mortality. And for some, the cost of extending life isn’t financial, it’s the pain and anguish associated with delaying the inevitable.

Most people would like a quick and painless death, but unfortunately that’s the exception. Death is more likely to come after a long medical struggle with an incurable illness. While death is certain, its timing isn’t, partly because medical science can now prolong the dying process considerably.

For some, ‘fighting to the end’ provides purpose. For others, it can seem painfully pointless.

False choices

Some people face unbearable suffering at the end of their lives, suffering in the form of physical pain, mental anguish, or both. The realisation that, in some circumstances, there’s no hope of a cure, let alone any respite from pain, can understandably result in feelings of despair. In these circumstances, it’s not surprising that some people want to die.

If an Australian gets to this point, he or she has three main options.

The first ‘choice’ is to ask that life-prolonging treatment be withheld or withdrawn. This is sometimes called passive voluntary euthanasia and may involve terminal sedation.

The second ‘option’ is to ask for an increase in the medication designed to alleviate pain, even if such an increase may shorten the patient’s life. Legally, it’s necessary for a sympathetic doctor to deny any intention of hastening death.

The third ‘choice’, which is not a legal option in Australia, is to obtain medical help in administering a life-ending drug. This is called voluntary euthanasia, or physician-assisted suicide.

While death is certain, its timing isn’t, partly because medical science can now prolong the dying process considerably.

Growing debate

Despite the historically strong opposition to terminally ill people being able to take responsibility for the way their lives end, the issue is subject to increasing debate, both here in Australia and around the world.

The power of the church is declining and cultural values are changing. And, after decades of being told that individuals, not governments, are best placed to make decisions, it’s understandable that a growing number of people want to take responsibility for one of the biggest decisions of all.

Public opinion polls on voluntary euthanasia are becoming more frequent and they show that public support for physician-assisted suicide is overwhelming. Over 80% of Australians believe in the right of the terminally or incurably ill to obtain medical assistance to end their lives.

This strong level of community support reflects the reality that doctors already act to relieve suffering by helping terminally ill people die peacefully. But despite public opinion and medical practice, doctors risk prosecution in Australia if they assist someone to commit suicide.

Current laws condemn people to needless suffering, deny individuals the right to make the most personal of choices and ignore the reality that doctors are already helping people to die.
Opposition

Surveys show the public wants legislative reform to give terminally or incurably ill adults the choice of a medically-assisted death. So why isn’t anything being done?

Opponents of physician-assisted suicide are articulate, determined and well-funded. Some opponents of change fear abuse of the vulnerable and an inevitable descent towards involuntary euthanasia, while some have strong beliefs about how other people should live and die.

There’s institutional opposition from some churches on the basis that physician-assisted suicide is simply wrong because their faith tells them so. But it seems that it’s elements of the religious hierarchy, not ordinary Christians, who are opposed.

A 2007 Newspoll found that 74% of those respondents who claimed to belong to a religion agreed that doctors should be allowed to provide a lethal dose to a patient experiencing unrelievable suffering and with no hope of recovery. A more recent poll showed that 65% of Australian Christians believed in legal voluntary euthanasia, with 73% aged more than 65 in favour.

Some opponents fear abuse of the vulnerable and an inevitable descent towards involuntary euthanasia, while some have strong beliefs about how other people should live and die.

So from a democratic point of view, the case for voluntary euthanasia is unassailable. The vast majority of people want it, and the leaders of the groups that are the most strongly opposed to it are at odds with those they claim to represent.

Ideologically, it’s hard to see how a society that increasingly questions the ability of government to make better decisions than individuals can continue to avoid a parliamentary debate about whether the government or the patient should have the final say in whether a treating doctor can assist suicide.

While the Greens support the legalisation of voluntary euthanasia, the stated policies of both major parties are completely at odds with majority opinion. No doubt this will change in time, but the longer that takes, the more people will suffer unnecessarily.

Imaginary slippery slope

Protection for the vulnerable will be central to any serious debate about legislative change in this area. Opponents of voluntary euthanasia regularly voice their fear of a ‘slippery slope’ that could lead to the killing of vulnerable people.

Similar laws in other countries are designed to address this concern, and a number of government and independent reviews have demonstrated that the laws work as intended.

Legislation for medically-assisted dying exists in the Netherlands, Switzerland, Belgium, Luxembourg, and two American states – Oregon and Washington State. It’s also legal in Montana as a result of a court ruling.

The standard legislative safeguards that exist in these countries include requirements that the patient is acting voluntarily and is not being coerced, that he or she is mentally competent (and not suffering from depression), and that the patient makes a fully informed decision.

In response to the fear of abuse of the vulnerable, research conducted in 2007 found that “rates of assisted dying in Oregon and in the Netherlands showed no evidence of heightened risk for the elderly, women, the uninsured, ... people with low educational status, the poor, the physically disabled or chronically ill, minors, people with psychiatric illnesses including depression, or racial or ethnic minorities, compared with background populations. The only group with a heightened risk was people with AIDS.”

The most recent comprehensive study of the subject is the Royal Society of Canada’s Expert Panel report on end-of-life decision-making, which was published in November 2011. One of its conclusions was: “The evidence does not support claims that decriminalising voluntary euthanasia and assisted suicide poses a threat to vulnerable people.”

“...The evidence does not support claims that decriminalising voluntary euthanasia and assisted suicide poses a threat to vulnerable people.”

Stepping up to the challenge

There are lots of reasons for people, and politicians, to be squeamish about this issue.

It’s obviously easier to ignore it and hope for the best. But it’s not the job of our representatives to avoid hard issues, it’s their job to confront them.

The public supports legalising assisted suicide, the medical profession is already doing it, and other countries have showed us that safeguards work.

If the only reason stopping us from ending the needless suffering of those approaching death in severe pain is the beliefs of a small number of leaders from a small number of churches, then maybe we should ban abortion, divorce and pre-marital sex as well.

Richard Denniss is adjunct professor, Crawford School at Australian National University.

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DEADLY CENSORSHIP GAMES: KEEPING A TIGHT LID ON THE EUTHANASIA DEBATE

Why don’t we talk about death and dying? We can choose so many of our life experiences, but it seems we can have no say in whether we die in pain or at peace. Brian Martin takes a look at the Australian government’s efforts to suppress discussion of euthanasia

There’s plenty of information available on how to kill yourself violently, so why does the Australian government so vigorously censor information on peaceful methods? Voluntary euthanasia societies have long been pushing to legalise death with dignity. According to opinion polls, a strong majority of Australians support legalisation, yet Australian governments have been unreceptive. When the Northern Territory government legalised euthanasia in 1996, the federal parliament overruled the law less than a year later.

Philip Nitschke, despairing of the legal route, set up Exit International to enable people to learn how to obtain a peaceful death through their own initiative. Exit publications provide information about obtaining pentobarbital, commonly known as Nembutal, the drug of choice everywhere that death with dignity is legal.

The Australian government vigorously censors information about peaceful ways of dying even though we have access to violent means of ending life.

CENSORSHIP AND RESPONSE

The Australian government has responded with amazingly draconian censorship. No other government has taken such extreme measures to prevent access to information on peaceful death.

Exit had an information phone line. The government passed a law making it illegal to convey information over the telephone about ending one’s life. Exit responded by putting its phone line in New Zealand.

Exit has a website. The government banned Australian internet service providers hosting websites with end-of-life information. Exit hosted its website overseas.

For some years, the government has been pushing for a web filter, ostensibly to block material on paedophilia and violent pornography. The government kept secret its list of websites to be blocked but the list was revealed on WikiLeaks – and it contained euthanasia websites. Exit responded by providing information about using proxy servers to get around the filter.

Philip Nitschke and Fiona Stewart wrote a book, The Peaceful Pill Handbook, with detailed information about peaceful ways to end your life. The book is freely available in most of the world, but the Australian government banned it. This was only the third book banned in Australia in a third of a century. Exit makes it easy to obtain the book, in hard copy or electronic form, from its websites.

Exit produced a short advertisement with the mild message that being able to choose how to die might be a good idea. Prior to filming, it was approved by the regulatory body Commercials Advice.

Afterwards, just before screening, Commercials Advice withdrew its approval. Exit put it on YouTube, where it was free to view, and some Australian media ran the story of how it had been censored.

Exit has also encountered legal threats, last-minute refusals to use hired venues and attempts to block its billboard advertisements.

Many people are keen to obtain the information provided by Exit. Nearly all of those who attend Exit’s meetings are old – the minimum age to attend the members-only segments is 50. Some are seriously ill. They are looking for information on how they can end their lives peacefully, when pain, indignity and suffering become too great. The government is doing its utmost to prevent this.

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VIOLENT DEATH

However, the government seems quite complacent about the availability of information about killing yourself violently.

Licensed handguns are legal in Australia, and you can take a course in how to use them. Shooting is one of the common ways men commit suicide. There are plenty of films and television shows with graphic portrayals of suicide by firearm.

The most common method for suicide in Australia is hanging. The technology – rope and something to tie it to – is readily available. Again, there are many media portrayals. For example, The Shawshank Redemption, a film rated very highly by audiences, includes an informative sequence of suicide by hanging.

The government is doing little or nothing to prevent access to information about violent suicide options.

It does not require much imagination to figure out how to kill yourself by jumping off a building, drowning or crashing a car, or you can look up suicide methods on Wikipedia. Shooting, hanging and other violent methods are not nice ways to die. They are unreliable: you might survive and end up permanently disabled. They are painful, often agonising. And they are highly distressing for family and friends.

The government is trying to prevent people suffering from terminal illnesses from finding out how to die peacefully. The result is that many of them choose violent methods instead, such as hanging. Yet the government is doing little or nothing to prevent access to information about violent suicide options.

RATIONALES

It might be argued that the government can’t prevent access to information about means for violent death – that would be censorship. But of course it has shown itself quite willing to censor information about methods for peaceful death.

Another argument is that people shouldn’t be able to choose a peaceful death, because that would make it too attractive. The evidence shows, on the contrary, that having the means to die peacefully frequently enables people to live longer.

Nor is there much risk of accidentally dying with the means described by Exit. Nembutal is extremely bitter, so no one is going to swig down a bottle by mistake. Another option, making an exit bag, requires considerable advanced planning and preparation. It is not a spur-of-the-moment suicide option.

The standard explanation is that the government is pandering to the religious lobby, which apparently is more concerned about stopping dying with dignity than stopping violent suicides.

The irony is that while physician-assisted suicide remains illegal, there is increased interest in Exit’s approach. So far, Exit has found a way around every censorship technique introduced by the government.

In some cases, the censorship has simply created more visibility for and interest in Exit’s activities. The government seems to have accomplished an unlikely double: appeasing the religious lobby while stimulating the development of ever better information and technology for do-it-yourself death with dignity.

Brian Martin is a Professor of Social Sciences at the University of Wollongong.

Acknowledgements: I thank Paula Arvela, Trent Brown, Rae Campbell, Philip Nitschke, Russel Ogden and Fiona Stewart for helpful comments.
Humanists adopt a philosophy based on human values, human knowledge of the natural universe, the lessons of history, personal experience and the application of reason.

Humanism is based on the belief that we are responsible for our own destiny. Humanism stresses an individual’s dignity and worth and capacity for self realisation.

Most humanists reject any notion of the supernatural, and therefore reject the idea that our lives are presided over by any supernatural force or ‘god’, or that our ethics and standards of behaviour are ‘handed down’ to us by ‘divine authority’.

Humanists argue that the basis for morality and moral action is the welfare of humanity rather than fulfilling the will of some god. (I differ here to some degree because the supremacy of humans is putting great pressure on the natural environment and I think it is in our interests as well as other species of plant and animal, to take stock and at least limit our exponential growth.)

Humanists argue that the basis for morality and moral action is the welfare of humanity rather than fulfilling the will of some god.

In our view humans create our own purpose and use our intelligence, knowledge, and compassion to build good lives for ourselves and for future generations.

We reject the idea that our existence serves some predetermined ‘purpose’ or value in life or in death, except perhaps to say that in dying we vacate the field for new life.

We understand the reality and finality of death as natural.

The meaning and value of life is simply the meaning and value that we as an individuals give it.

Philosopher, AC Grayling says: ... the meaning of life consists in what you create through the identification and pursuit of endeavours that your talents fit you for and your interests draw you to, together with the relationships you form in the process.

First and foremost, good relationships give meaning to life; so does the pursuit of worthwhile goals; so do pleasure and enjoyment; so do respect and friendship, both given and received in the course of endeavour.

People are various, life is various, circumstances differ; there are many ways in which life can be good, flourishing and meaningful, just as there are many causes of misery and failure, despair and tragedy.

No one should attempt to tell anyone else what is valuable in life and what is not with the proviso that it is never right to do harm to others in the pursuit of value in your own.

We take comfort in celebrating the life of the dead rather than denying its finality with expectations of reincarnation or reunion in heaven.

Humanists do not believe that a god determines whether and when individuals are conceived, are born or die.

We take comfort in celebrating the life of the dead rather than denying its finality with expectations of reincarnation or reunion in heaven or in communion with god.

We can’t find any evidence to suggest that people who hold religious beliefs or who are innocent of wrong doing are rewarded with long and
valuable lives or easy good deaths or indeed that there are rewards in heaven or punishment in hell.

We say death is an end to life of the individual, that there is no after life or eternal life in some other place.

And this leads us to want for ourselves and others some choices in the process and timing of dying.

My grandmother used to wish to die peacefully in her sleep, presumably with neither suffering nor awareness. Instead she died in great pain and distress.

Most of us don’t want to admit that we will one day die or to think about it too much but when pressed, we all want to die without intolerable suffering and without loss of control or dignity as one does in dying from dementia for instance.

We may not fear death but we will almost certainly fear what we might have to endure before we die.

Doctors and nurses and hospital administrators make difficult life and death decisions every day – to turn off life supports, to make heroic interventions to save the lives of very premature babies, to transplant organs from the dead, to make some drugs or tests available to some but not others and to stop treatment for those with advanced and terminal illness.

We may not fear death but we will almost certainly fear what we might have to endure before we die.

Death is now highly medicalised – a natural death now uncommon.

And there is no doubt that doctors do prolong inevitable deaths and do routinely and deliberately hasten others.

The problem, for those of us who want a say in decisions about our own death and the process of dying, including a hastened death, is that the law does not allow intentional physician-assisted death and doctors who provide this assistance in response to a patient’s request, are at greater risk of being prosecuted for a criminal offence with a sentence of up to 14 years jail.

So the prohibition in effect discourages the request for assistance and consent in its delivery.

Over 80 per cent of Australians have consistently demonstrated that they want the law changed to give them this choice to avoid suffering which they deem intolerable, with the help of doctors willing to give that help.

(It is interesting to note that a similar percentage choose a civil celebrant to conduct their or their family member’s funeral.)

There is no doubt that palliative care has made the process of dying more tolerable for most.

Pain is relieved and the medication used in doing so will probably hasten death through terminal sedation, however, not all pain can be relieved – bone cancer is a case in point – and some conditions cause great discomfort and distress that can only be relieved by death.

Wasting, exhaustion, extreme difficulty breathing, choking, nausea are common for some diseases at end of life.

I would not want to endure these symptoms for the sake of living a few hours or days or even a few months longer than might otherwise be the case. To deny me that choice is to deny me my autonomy – to treat me as being not fully human.

No one knows until they actually face death, how they will respond. The experience of Dr Rodney Syme and the people he has given the means to take their own lives is that this assurance that they can end their suffering if they need to, is itself palliative – it removes the terror and allows them to face the end with calmness and dignity. In the US state of Oregon around a third of terminally ill patients provided with medication to end their lives do not in the end use it.

I hope I have that courage when I am forced to face death, rather than die peacefully in my sleep, but as a humanist I will want to find it from knowledge and wisdom, the power to exercise autonomy and, hopefully, satisfied that I have lived a mostly good and worthwhile life and been of some value to my fellow human beings.
EXPLORING ISSUES

ABOUT THIS SECTION
‘Exploring issues’ features a range of ready-to-use worksheets relating to the articles and issues raised in this book.

The activities and exercises in these worksheets are suitable for use by students at middle secondary school level and beyond.

As the information in this book is gathered from a number of different sources, readers are prompted to consider the origin of the text and to critically evaluate the questions presented.

Does the source have a particular bias or agenda? Are you being presented with facts or opinions? Do you agree with the writer?

The types of ‘Exploring issues’ questions posed in each Issues in Society title differ according to their relevance to the topic at hand.

‘Exploring issues’ sections in each Issues in Society title may include any combination of the following worksheets: Brainstorm, Research activities, Written activities, Discussion activities, Quotes of note, Ethical dilemmas, Cartoon comments, Pros and cons, Case studies, Design activities, Statistics and spin, and Multiple choice.

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WORKSHEETS AND ACTIVITIES
Brainstorm, individually or as a group, to find out what you know about voluntary euthanasia.

1. What is the difference between voluntary and non-voluntary euthanasia?

2. What is passive euthanasia, and how does it differ from active euthanasia?

3. What is assisted suicide?

4. What is an ‘advance directive’, and why is it considered important?
Voluntary euthanasia and assisted suicide have been legally available in several places in the world for over a decade. A large percentage of adult Australians are reported to believe that a person who is suffering and close to death should be able to have access to a means to end their life at a time they choose.

How do you think Australia should regulate voluntary euthanasia? Make a list of arguments for and against the legalisation of voluntary euthanasia in Australia. Include at least 4 points for each line of argument, and then discuss your own personal conclusions in a larger group.

<table>
<thead>
<tr>
<th>Argument for Legalisation</th>
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<tbody>
<tr>
<td>1. Quality of life decline</td>
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<tr>
<td>2. Right to die with dignity</td>
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<tr>
<td>3. Palliative care limitations</td>
</tr>
<tr>
<td>4. Reduces suffering and distress</td>
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<table>
<thead>
<tr>
<th>Argument against Legalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increased risk of coerced killing</td>
</tr>
<tr>
<td>2. Potential for abuse and misuse</td>
</tr>
<tr>
<td>3. Inadequate safeguards and oversight</td>
</tr>
<tr>
<td>4. Moral and ethical implications</td>
</tr>
</tbody>
</table>

My conclusions: 

Discussion in larger group:

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MULTIPLE CHOICE

Complete the following multiple choice questionnaire by circling or matching your preferred responses. The answers are at the end of this page.

1. In which year did the Northern Territory introduce the Rights of the Terminally Ill Act:
   a. 1978
   b. 1995
   c. 1996
   d. 2010
   e. Never

2. Who is recorded as being the first person to use the term ‘euthanasia’ in a medical context:
   a. Suetonius
   b. Francis Bacon
   c. Dr Philip Nitschke
   d. Hippocrates
   e. Thomas Aquinas
   f. Felix Adler

3. What is the approximate percentage of Australians that believe there should be a legal option of aid-in-dying for hopelessly ill patients experiencing unrelievable suffering with no chance of recovery:
   a. 25%
   b. 45%
   c. 55%
   d. 85%
   e. 99%

4. Match the following countries with the current legal status of euthanasia:

   1. Australia
      a. Euthanasia is illegal and any person found assisting suicide will be convicted of assisting suicide or attempting to do so.

   2. Belgium
      b. Euthanasia is now illegal throughout the entire country, however it was once legal for a period of nine months in one area of the country.

   3. Japan
      c. Assisted suicide and voluntary euthanasia remain illegal. It is a criminal offence to ‘aid and abet suicide’.

   4. Mexico
      d. There are no official laws on the status of euthanasia in this country.

   5. Netherlands
      e. In 2002, a law was passed legalising euthanasia including physician-assisted suicide.

   6. New Zealand
      f. Active euthanasia is illegal in most areas of this country, however there are three states where assisted suicide is legal.

   7. Switzerland
      g. Active euthanasia is illegal, however since January 2008 the law allows the terminally ill to refuse medication or treatment to extend life.

   8. United Kingdom
      h. Euthanasia was legalised in late September 2002.

   9. United States
      i. Deadly drugs may be prescribed where the recipient takes an active role in the drug administration.

MULTIPLE CHOICE ANSWERS

1 = b ; 2 = b ; 3 = d ; 4 – 1 = b, 2 = h, 3 = d, 4 = g, 5 = e, 6 = c, 7 = i, 8 = a, 9 = f.
Voluntary euthanasia is legal in a number of places including Switzerland, Germany, Japan, Oregon, Washington, and Texas. (p.17)

- In the Netherlands, euthanasia is understood as "termination of life by a doctor at the request of a patient". (p.1)
- Euthanasia was legalised in Australia’s Northern Territory, by the Rights of the Terminally Ill Act 1995. Soon after, the law was voided by an amendment by the Commonwealth. (pp.1, 2, 3, 6-7, 17, 39, 49)
- As of 2011, active euthanasia is only legal in the 3 Benelux countries: the Netherlands, Belgium and Luxembourg. (p.3)
- The Belgian parliament legalised euthanasia in late September 2002. (p.3)
- Canadian euthanasia and assisted suicide law is currently in legal limbo. (p.3)
- A September 2010 Irish Times poll showed that a majority, 57% of adults, believed that doctor-assisted suicide should be legal for terminally ill patients who request it. (p.3)
- The Israeli penal law forbids causing the death of another and specifically forbids shortening the life of another. (p.3)
- Luxembourg was the third European Union country, after the Netherlands and Belgium, to decriminalise euthanasia. (p.4)
- Dr Nigel Cox is the only British doctor to have been convicted of attempted euthanasia. He was given a 12-month suspended sentence in 1992. (p.5)
- The only end-of-life laws that exist in Australia are a patchwork of advance medical directive and power of attorney laws, none of which allows a person to ask for active assistance to die. (p.6)
- An advance medical directive is a legal document that is signed in advance to extend a person’s absolute right to refuse medical treatment into circumstances where the ability to communicate is lost. (p.6)
- In Victoria, the Medical Treatment Act (1988) allows a patient to write a ‘refusal of treatment’ certificate, but only for a current illness, and the illness need not be terminal. (p.7)
- For over four decades a majority of Australians have believed there should be a legal option of aid-in-dying for those suffering intolerably and without relief near the end of life. (pp.8, 9)
- Current support for voluntary euthanasia is 85% of Australians including three out of four Catholics, four out of five Anglicans, and nine out of ten Australians with no religion. (pp.8, 9, 10)
- A significant proportion of Australian doctors believe that aid-in-dying should be legally available. (p.8)
- Since 1995, every Australian state and territory except Queensland, introduced a form of euthanasia legislation which subsequently was either defeated or overturned or lapse. (p.11)
- Harold Shipman who was also known as ‘Dr Death’, was found guilty of 15 murders, a subsequent inquiry positively ascribed to him 218 murders. (p.16)
- Voluntary euthanasia is legal in a number of places including Switzerland, Germany, Japan, Oregon, Washington, and Texas. (p.17)
- The U.S. State of Oregon does not consider physician-assisted suicide as euthanasia under the Oregon Death with Dignity Act. (p.17)
- Euthanasia and physician-assisted suicide are not part of palliative care practice. (p.18)
- Advance directives are legally binding in every state and territory in Australia. (p.19)
- Fundamental to a well-functioning and just society is the prohibition of intentional killing. Sometimes this is expressed as the ‘sanctity of life’ principle or the ‘inviolability of life’ principle. (p.21)
- In 2009 the Queensland Elder Abuse Unit estimated the prevalence of elder abuse to between 13,896 and 42,757 older people. (p.25)
- More than half the palliative care in Australia is provided by Catholic institutions. (p.31)
- In Belgium, the law permits only doctors to perform mercy killings. Yet nurses perform euthanasia in 12% of cases, and 45% of cases of unrequested assisted deaths. (p.31)
- The literature of psychiatry contains abundant evidence that the sustained wish to die is associated, in a large number of the seriously ill, with depression, which alters mood and inhibits the ability to reason coherently. (p.34)
- Two wide-ranging studies in the 1990s revealed alarming levels of abuse in relation to end-of-life decisions. Each of the studies showed that in a climate where voluntary euthanasia is condoned, abuse is prevalent. (p.37)
- A survey of 500 doctors by Exit International found that 60-70% of GPs in Victoria, SA, NSW and WA were in favour of euthanasia laws. (p.39)
- Even the best of palliative care cannot help all patients – between 15-10% find their suffering so unbearable that they persistently request an assisted death. (pp.40, 44)
- A survey in 1987 of 869 Victorian doctors found that 93% believed that a request for voluntary euthanasia could be rational. A survey in 1993 of 1,268 NSW doctors found that 96% concurred, as did a survey in South Australia of 298 doctors in which 89% considered that such a request could be rational. (pp.41, 43)
- A 1997 study showed that nearly 1 in 50 deaths is already physician-assisted dying. (p.44)
- A 1997 professional study found that 45% of physicians did not believe that present arrangements are adequate, 68% believed that physician-assisted dying can be an act of caring, and 45% wished to have the option of physician-assisted dying. (p.44)
- Formal statistics from 9 years of operation in Oregon show that only a minority of sufferers actually go through the process to obtain permission for medical assistance to die. (pp.45, 52)
- Around 85% of us will die in hospital of a terminal illness rather than “passing away quickly and peacefully in our sleep” at home. (p.46)
- A recent poll showed that 65% of Australian Christians believed in legal voluntary euthanasia, with 73% aged more than 65 in favour. (p.48)
**Advance directive**
Also known as a ‘living will’. This is a document that expresses a person’s wishes to his/her doctor when that person is unable to communicate regarding medical treatment in the event of there being no reasonable prospect of recovery from a serious illness which is expected to cause the patient severe distress or render him/her incapable of rational existence.

**Assisted suicide**
The act of intentionally, knowingly and directly providing the means of death to another person, at the request of the patient, with the intention of relieving intolerable suffering, in order that the person can use that means to commit suicide. If the person who dies performs the last act, assisted suicide has occurred.

**Autonomy**
The ability of a person to make his or her own decisions.

**Brain dead**
The termination of brain function, as evidenced by the loss of all reflexes and electrical activity of the brain – irreversible coma.

**Do not resuscitate order (DNR)**
A written order placed on a patient’s medical chart to indicate that there should be no attempt to restart a failed heartbeat or restore breathing by any means such as using CPR (cardiopulmonary resuscitation), a ventilator, electrical stimulation, or use of medications.

**Double effect**
An ethical principle used to justify medical treatment that is designed to relieve suffering, where death is its unintended (though foreseen) consequence. The rule does not authorise practices such as physician-assisted suicide, voluntary euthanasia, and certain instances of foregoing life-sustaining treatment.

**Euthanasia**
The act of intentionally, knowingly and directly causing the death of a patient, at the request of the patient, with the intention of relieving intolerable suffering. If someone other than the person who dies performs the last act, euthanasia has occurred.

**Non-voluntary euthanasia**
Also known as ‘mercy killing’. This is when euthanasia is conducted without the consent of the individual as they are unable to give consent. Most commonly used in medical situations.

**Palliative care**
An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

**Passive euthanasia**
The deliberate disconnection of life support equipment, permitting the natural death of the patient.

**Physician-assisted suicide**
Similar to voluntary euthanasia but distinguished by a physician prescribing but not administering the lethal drug.

**Right to die**
The ethical or institutional entitlement of the individual to commit suicide or to undergo voluntary euthanasia. Often associated with the idea that one’s body and one’s life are one’s own to dispose of as one sees fit. On 25 May 1995, the Northern Territory became the first place in the world to pass right to die legislation. The *Rights of the Terminally Ill* Act lasted 9 months before being overturned by the Federal Parliament.

**Sanctity of life**
A religious concept that holds that life is a gift from God and so can only be ended by God.

**Slippery slope**
An argument frequently used against changing the law, which states that it is impossible to set secure limits. Under this argument, it is claimed that voluntary euthanasia would eventually and inevitably lead to non-voluntary or even involuntary euthanasia.

**Suicide**
The intentional taking of one’s own life.

**Terminal illness**
An illness for which there is no known cure and therefore no chance of recovery. When a person is diagnosed as terminally ill, death is expected in a relatively short period of time.

**Terminal sedation**
The deliberate sedation of a patient to place them in a state of deep unconsciousness to relieve suffering. The drugs used in this process can often hasten death. During this process the patient is often not provided with food or fluid in anticipation of death.

**Voluntary euthanasia**
Death brought about by a doctor at the request of the person who dies. Voluntary euthanasia societies around Australia have been campaigning for years to change the law so that someone who is incurably ill can receive medical help to die at their persistent and considered request.
Websites with further information on the topic

Australian Christian Lobby International  www.acl.org.au
Australian Federation of Right to Life Associations  www.righttolife.asn.au
Christians Supporting Choice for Voluntary Euthanasia  www.christiansforve.org.au
Dying with Dignity NSW  www.dwdnsw.org.au
Dying with Dignity Queensland  www.dwdq.org.au
Dying with Dignity Victoria  www.dwdv.org.au
Dying with Dignity Tasmania  www.dwdtas.org.au
Doctors for Voluntary Euthanasia Choice  http://drs4vechoice.org
Exit International  www.exitinternational.net
Northern Territory Voluntary Euthanasia Society  www.ntves.org.au
Right to Life Australia  www.righttolife.com.au
South Australia Voluntary Euthanasia Society (SAVES)  www.saves.asn.au
Southern Cross Bioethics Institute  www.bioethics.org.au
West Australian Voluntary Euthanasia Society Inc. (WAVES)  www.waves.org.au
World Federation of Right to Die Societies  www.worldrtd.net
Your Last Right.Com Ltd (Aus)  www.yourlastright.com

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THANK YOU
* Exit International
* Queensland Bioethics Centre
* South Australian Voluntary Euthanasia Society.

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