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# Bioethics Outlook

## Plunkett Centre for Ethics

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## Australia moves closer to legalizing 'euthanasia'

**Bernadette Tobin**

Why the inverted commas around the word 'euthanasia'? Well, as the Australian scholar of jurisprudence, John Finnis, pointed out, the term is one *invented to persuade*. Made up by putting together two Greek terms - 'eu' meaning 'well' and 'thanatos' meaning 'death' -, it's intended to foster a 'pro attitude' to a change in the law *without giving us a reason to think such a change would be a good one*.

Language matters. Every time the proponents of a change in the law soften the term they use, the proportion of the population in favour of legalizing the practice goes up. So we have witnessed the move from 'euthanasia' to 'physician-assisted suicide', to 'physician-assisted dying', to 'physician-assisted death', to 'PAD' ! Archbishop Anthony Fisher - who rightly reminds us that no one should romanticize death - invites us to call a spade a spade. His term is 'state sanctioned medical killing' which he uses both for the law's permitting a doctor to do it to her patient and for its permitting a doctor to give her patient the means to do it to himself.

In this issue, we republish two recent contributions to the discussion of the increasingly-frequent moves to change the law to allow doctors (under certain circumstances) intentionally to bring about the death of their patients in order to relieve suffering. Why these two articles? In the first, Paul Kelly identifies legalizing killing as the moral and social *tipping point*: that's the moment that, as a society, we cross the Rubicon and everything is different after that. In the second, Anthony Fisher reminds us that, in human life, there are some things for which no government inquiries, law reform or Nembutal can or will make

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good or, as he puts it, some things *for which there is no morally or practically available fix*. And we add a short note about a recent opinion piece in the Chicago Tribune in which the prominent American bioethicist, Arthur Caplan, and two colleagues draw attention to the difficulty, once it is legalized, of containing euthanasia *even within the medical sphere*.<sup>1</sup>

Of course, there is much that is wrong with end of life care in Australia.

According to the President of the AMA, there are so many gaps in service that many people are reliant on the private health system in Australia for decent palliative care.<sup>2</sup> What a criticism of our generally-admirable public health system! No wonder there are such vocal proponents of a change in the law to permit doctors intentionally to bring out the death of their patients. Many have been first hand witnesses to downright incompetent end of life care of someone they love.

Indeed, there are still doctors who do not recognize their patient's (moral and legal) entitlement to pain relief and symptom control (even in circumstances in which that will hasten death!). Some are confused about the *straightforward* difference between (a) choosing to relieve someone of their pain and suffering by giving drugs, in a dosage determined by the drugs' capacity for relief of pain and suffering, foreseeing that the drugs in that dosage will cause death and (b) choosing to kill someone with drugs to relieve the person of pain and suffering. Others appear to see an advantage in fostering that confusion.

And, despite the best efforts of Faculties of Medicine to address the need for professional training in the latest effective techniques of pain relief and symptom control, medical students sometimes skip the lectures in palliative medicine, there being other, more glamorous, specialties to pursue.

To conclude. Any model of 'law reform' must be unstable. The more effective the so-called safeguards, the more restricted and thus 'unfair' will be access to the service. Elizabeth Anscombe pointed out years ago: *'So far, most propaganda for euthanasia assumes it should be voluntary... This impresses because it strikes people as not wronging someone to kill him if he wills it. However it needs pointing out that they would still think it was wronging him, but for the accompanying judgment that his condition is so irremediably wretched that it is fortunate for him 'to die'. This judgment is paramount, and that is why the stress on voluntariness tends to be spurious.'*<sup>3</sup>

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<sup>1</sup> 'Physician-assisted suicide: only as a last resort', *Medscape*, 24 September 2014:

[www.medscape.com/viewarticle/831314](http://www.medscape.com/viewarticle/831314); accessed 4<sup>th</sup> December 2016

<sup>2</sup> Dr Michael Gannon, interviewed on ABC Radio National Breakfast Program: 24<sup>th</sup> November 2016

<sup>3</sup> Elizabeth Anscombe. 'Murder and the Morality of Euthanasia' in *Human Life, Action and Ethics*, edited by Mary Geach and Luke Gormally, Imprint Academic, 2005

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# Legalise euthanasia, and compassionate society dies too

**Paul Kelly**

If you love your parents, respect your children, care for your society and think compassionately about your world then it is time to open your heart and brain to what happens when a jurisdiction legalises killing or, as it is called, euthanasia.<sup>4</sup>

The justification for euthanasia lies in human rights, individual autonomy and relieving pain — all worthy ideas, and that may prompt the question: why then is euthanasia still opposed by most nations, most medical professional bodies around the world and the Australian Medical Association?

The reason is not hard to find. It is because crossing the threshold to euthanasia is the ultimate step in medical, moral and social terms. A polity is never the same afterwards and a society is never the same. It changes forever the doctor-patient bond. It is because, in brutal but honest terms, more people will be put at risk by the legislation than will be granted relief as beneficiaries.

The argument against euthanasia has endured for many years: it leads, on balance, to a less compassionate society that creates a new series of moral and practical hazards for itself. It is a disproportionate response to the real problem of patient pain that needs more care and money. It is because a society that legalises killing has to change fundamentally in terms of the ethics of its doctors, its medical ethos, its family relationships and its principles of human life. Belgium, having legalised euthanasia in 2002, offers a tragic picture of what can happen to a country just a few short years later.

In this debate the principle of individual autonomy is vital. Adults, as much as possible, should be able to exercise choices over their medical treatment. That means declining treatment that can keep them alive. There is no real dispute about that.

Euthanasia is different: it is an act that terminates life. It is, therefore, by definition not a private affair; not just about a patient's right. It is a public and society-wide issue because it involves the state legalising killing subject to certain conditions. That is a grave step and it concerns everyone.

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<sup>4</sup> *The Australian* October 1, 2016; reprinted with permission of the author

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AMA head Michael Gannon tells Inquirer:

*“The current policy of the AMA is that doctors should not involve themselves in any treatment that has as its aim the ending of a patient’s life. This is consistent with the policy position of most medical associations around the world and reflects 2000 years of medical ethics.”*

There are three foundational points in this debate. First, in relative terms the proportion of people dying in acute pain is declining because palliative care methods have been enhanced. There is wide agreement among experts that most physical pain at life’s end can now be managed — this is a critical trend but cannot conceal the fact painful deaths still exist and become the main argument for legal change. But euthanasia should not be seen as a substitute for palliative care — that would be a medical and moral blunder.

Second, where euthanasia is legalised the record is clear — its availability generates rapid and ever expanding use and wider legal boundaries. Its rate and practice quickly exceeds the small number of cases based on the original criteria of unacceptable pain — witness Belgium, The Netherlands, Switzerland and Oregon. In Belgium, figures for sanctioned killings and assisted suicide rose from 235 in 2003 to 2012 by last year. In the Netherlands they rose from 2331 in 2008 to 5516 last year.

These figures come from Labor MLC Daniel Mulino’s minority report in the recent Victorian Parliament Committee Report recommending euthanasia. His conclusion is that

*“the negative consequences arising from legislation far outweighs the benefits arising in that minority of cases”.*

Experience in other jurisdictions leads to the unambiguous conclusion: the threshold event is the original legalising of euthanasia. After this there is only one debate — it is over when and how to expand the sanctioned killings. Claims made in Victoria that strict safeguards will be implemented and sustained are simply untenable and defy the lived overseas experience as well as political reality. There are many questions. If you sanction killing for end-of-life pain relief, how can you deny this right to people in pain who aren’t dying? If you give this right to adults, how can you deny this right to children? If you give this right to people in physical pain, how can you deny this right to people with mental illness? If you give this right to people with mental illness, how can you deny this right to people who are exhausted with life?

Third, culture and values will change to justify the death process. Consider the situation of one of Belgium’s most famous doctors, Wim Distelmans, applauded as a human rights champion. Having killed more than 100 patients, he is a celebrity, gives talks around the nation and is lauded as a man who “cannot stand injustice”. He told *Der Spiegel* that giving a lethal injection is an act of “unconditional love”.

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In Belgium, because so many are killed, the act must be converted into the exemplar of moral and medical compassion. “Who am I to convince patients that they have to suffer longer than they want?” Distelmans said in one of the most astonishing articles of our time.<sup>5</sup> It is the story of how an adult son, Tom Mortier, sought justice after Distelmans killed his mother without Mortier’s knowledge. Distelmans was appointed chairman of the Federal Control and Evaluation Commission, whose job is to assess that doctors have complied with Belgian law. He told *The New Yorker*:

*“We at the commission are confronted more and more with patients who are tired of dealing with a sum of small ailments — they are what we call ‘tired of life’.”*

Though their suffering derived from social as well as medical concerns, Distelmans said he regarded their pain as incurable. The article reported that 13 per cent of Belgians who were euthanised last year did not have a terminal condition. In Belgium euthanasia and suicide march together — it also has the second highest suicide rate (excluding euthanasia) in western Europe. The most chilling aspect in a chilling story was Distelmans’s moral superiority in dealing with Mortier, prompting Mortier to write later:

*“I loved my mother for more than 30 years and I wanted her to live; Dr Distelmans loved her so much — ‘unconditionally’ — that after a few brief consultations over six months he gave her a lethal injection.”*

Once you sanction euthanasia you open the door to euthanasia creep. The human heart will always respond to the incentives of the law. Cross the threshold and doctors will be encouraged to think it is their job to promote the end-of-life. Sick people, thinking of families, feel obliged to offer up their deaths. Less worthy people exploit the death process for gain. In Belgium children can now be euthanised. Would this have been acceptable when euthanasia was legalised in 2002? No way.

The article quoted a professor of psychiatry at the University of Leuven, Dirk De Wachter, calling euthanasia a humanist solution to a humanist dilemma. “What is life worth when there is no God?” he asked. “What is life worth when I am not successful?”

There are an infinite number of similar questions: what is life worth when you are lonely or depressed? De Wachter said he had recently euthanised a woman, not suffering from clinical depression but in a condition where “it was impossible for her to have a goal in life”.

Pro-euthanasia advocates in Australia are split when dealing with Belgium and The Netherlands between defending their practices or saying they are not relevant to our debate. The latter is false. These countries are highly relevant — as classic studies in how the euthanasia culture takes grips of a nation’s moral sense. It is sanctioned in terms of love, liberation and compassion — the ultimate service one human can render another.

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<sup>5</sup> Rachel Aviv. “The Death Treatment”, *The New Yorker*, June 22, 2015

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The recent Victorian parliamentary report Inquiry into End of Life Choices recommended that people be assisted to die by being prescribed a lethal drug to be taken by themselves or administered by a doctor. It outlined a series of strict guidelines as eligibility criteria — approval by a primary doctor and a second doctor only for patients suffering at the end of life. The condition must be serious and incurable. The request must come from the patient and be free of coercion, be properly informed and be made three times: verbal, written, then verbal again.

There is significant support for euthanasia in the Victorian cabinet and in the opposing frontbench. A bill is certain in the life of the present parliament. Expectations are that it will be passed.

The AMA's Gannon says the association is conducting a review of its euthanasia policy. He says this is "routine" and not prompted by "recent events". He highlights the paradox of euthanasia. "It is only a rich country issue," Gannon says. "There is no one in the developing world talking about terminating the lives of patients." The AMA review will be completed in mid-November.

The pro-euthanasia group within the AMA hopes to shift its policy from opposition to neutral, mirroring the shift made in Canada — and that would be a significant step. In its evaluation the AMA must focus beyond the issue of patient autonomy to confront the question of doctor-patient-relations and how they would change under euthanasia. A critical feature of the Victorian report is the belief that a small number of people seeking euthanasia can be helped without any significant downside for society. It seeks to achieve this through robust eligibility criteria and the repudiation of any "slippery slope" problem with euthanasia in jurisdictions such as Oregon, The Netherlands and Switzerland.

Such optimism is heroic and typical of the euthanasia debate. It is echoed in nation after nation, year after year. It testifies to the deepest humanist conviction that mankind and wise governments can introduce euthanasia regimes with the necessary legal safeguards and the necessary regulatory protections to manage the promotion of death to ensure only net gains for the social order.

It is surely extraordinary that people sceptical of the ability of governments to get trains running on time fool themselves into thinking they can confidently manage a regime that sanctions the termination of human life.

The minority report from Mulino provides statistics showing there has been a sustained increase in deaths in all jurisdictions, no evidence that growth rates are plateauing with compound annual growth rates ranging from 13 to 22 per cent, which Mulino says has to be regarded as "extremely high". He says the total number of cases in Belgium has increased by 756 per cent over 12 years and in Oregon is 725 per cent higher across the 17 years since initial legislation.

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What sort of society is evolving if these growth rates continue? Why cannot we rationally confront and answer these questions? What drives the rise in deaths?

Mulino says the evidence reveals euthanasia and assisted suicide regimes “come under immediate pressure as soon as these schemes are enacted”. First, there is pressure to widen the law and second is the pressure to interpret more generously its implementation. And we think Australia is exempt?

There are many examples. In Canada, there are advisory group recommendations to extend the law to children. In Belgium extending euthanasia to dementia patients is under examination. The Netherlands is considering allowing patients to make pre-dementia declarations.

The trend and logic is unassailable: once legislated the principle of euthanasia is settled and the practice of euthanasia is widened, if not by law then by administrative laxity and de facto regulatory sanction. Of course, many euthanasia cases are never declared.

A 2012 report by the European Institute of Bioethics said: “Initially legalised under very strict conditions, euthanasia has gradually become a very normal and even ordinary act to which patients are deemed to have a right.”

Many advocates in Australia use the rights language. Once this takes hold, then holding back the tide is near impossible. The upshot in The Netherlands is that the type of patients seeking euthanasia has changed with a shift to those with psychiatric illness. Mobile clinics offering free lethal injections are now in operation.

Mulino refers to an Oregon Public Health Division report looking at 132 deaths and finding that 48 per cent listed being a burden on family, friends or caregivers was a concern. When the Belgian law was passed politicians insisted that patients with psychiatric disorders, dementia or depression would be excluded — yet the prospect now is for an escalation in these categories.

Vulnerable people are right to feel uneasy if Australia crosses the legal threshold. In truth, it is virtually impossible to ensure all acts of euthanasia are voluntary. The elderly, lonely, handicapped and indigenous need to think how such laws may affect them and their self-esteem.

In short, the foundational claims in the majority Victorian report of no “slippery slope” and effective “safeguards” do not pass the test of evidence, experience or careful analysis. This goes to the question of whether Australia will legislate on false and misleading assumptions that reflect ideological and political propositions.

On the pivotal and related issue of palliative care, Australia suffers a moral and humanitarian failure — and the Victorian report has responded with a strong set of recommendations.

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Palliative Care Australia chief executive Liz Callaghan tells Inquirer: “The practice of palliative care does not include euthanasia or physician-assisted suicide, and palliative care does not intend to hasten or postpone death. PCA believes the Australian government needs to increase access to palliative care.

*“Currently 70 per cent of Australians want to die at home but only 14 per cent do. We believe more needs to be done to ensure that this can happen. Access to integrated, comprehensive support and pain/symptom management is often inadequate, inequitable or may not meet patient needs.”*

Callaghan says evidence is that pain management improved from 2011 to last year based on data collection from 115 specialist palliative care services looking after 20,000 patients needing pain management. She says PCA believes more needs to be done to ensure people are better educated about their end of life care choices and palliative care.

The PCA believes any request for euthanasia requires “a respectful and compassionate response”, with Callaghan saying euthanasia is an issue for parliaments.

It is ironic this week that more evidence has emerged about the shocking impact of suicide in this country, particularly for Australians aged in the 15 to 44 age group. How, pray, does legalising euthanasia help the campaign against suicide? The most bizarre notion this week was the suggestion that legalising euthanasia may lower the suicide rate.

In many ways this entire debate is about how to interpret love and care in the context of death. Hug the person you love. But realise this is also about deciding the degree of discretion doctors have dealing with death. It may be good for a doctor to follow a patient’s wish for a lethal injection but that must be assessed against the total social impact of a regime that allows life to be terminated.

If we proceed then life will change, there will be a “slippery slope”, your relationship with your doctor will be different, the vulnerable will have reason to feel uneasy, the push to make euthanasia a right will be inevitable, the frail will feel obliged to volunteer and our values as a community will shift more quickly than you appreciate.



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# No Need for a Licence to Kill

## +Anthony Fisher

Recently I accompanied a priest friend as he was dying of cancer at the Sacred Heart Hospice in Sydney. He was only in his early 60s and when I celebrated his funeral it seemed to us onlookers to be too soon. Frank approached his death with resignation, good humour, even generosity. He said his goodbyes and prepared to say his hellos beyond the grave. Though helped by his personal faith, supportive family and priest friends, it was clear to me his last weeks would have been much harder were it not for palliative and pastoral care.<sup>6</sup>

My experience with Frank underlined for me that no one should romanticise dying whether they are campaigning for state-sanctioned medical killing in certain cases or, like me, think there's a better way to go. Both sides must face the same brutal fact: that death, like life, is rarely free from all pain and grief.

There are some things for which there is no morally or practically available fix. No end of government inquiries, law reform or Nembutal will make everything nice. We do our very best to manage pain and relieve suffering. But there remains some palliative deficit or existential suffering that calls for personal forbearance and support from others.

No one should pretend that's easy. Palliative care professionals do their best and today their best is very good. Most pain can be anticipated and blocked even before it begins; we don't have to wait until people are begging for relief. In really difficult cases patients may have to be rendered unconscious and only woken for only brief periods with their loved ones and carers.

Drugs, nutrition and hydration should be provided as long as they can achieve the goal or at least provide some comfort. But when these can no longer be absorbed they are rightly withheld. The focus changes from extending life to keeping the patient as comfortable as possible for the time they have left. In my experience that time can be precious for all concerned.

No one need fear that giving high but appropriate doses of pain relief or withholding too burdensome treatments is unethical or illegal: it is good practice, even if, like the rest of healthcare, it has its risks. Sure, it may in some cases mean the patient does not live as long

as they would if we tried everything. But the palliative approach is warranted in such cases and failing to adopt it could well be even more debilitating and life-shortening.

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<sup>6</sup> Anthony Fisher is the Catholic Archbishop of Sydney and a member of the Order of Preachers. This article first appeared in *The Australian* on 15/16 October 2016; reprinted with permission of the author

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All this is well understood in the palliative care world. It does not require changes to law or practice. But it does require greater resourcing if palliative care is to be available to all who may benefit. And we need better education of the community, even perhaps GPs, about end-of-life care. What we don't need is to give some people a licence to kill. We shouldn't be telling sick people by our laws that we think they would be better off dead or that we would be better off if they were dead.

Paul Kelly recently reported the dangerous consequences apparent in places such as Belgium that have gone down the path (*The Weekend Australian*, October 1-2 ). I need not repeat those here. But as we become more aware of widespread elder abuse and alarming rates of suicide among the vulnerable, we have more cause to be especially cautious about introducing the idea of killing the burdensome or volunteering for an early death.

There have been attempts recently to silence Catholics and other believers on euthanasia and other debates. Andrew Denton has spoken darkly of "subterranean Catholic forces" and told politicians and professionals with faith to butt out. But we surely need a serious and respectful discussion where all sides are heard and reasonable disagreement, and perhaps even agreement, is possible. I believe such civil discourse is still possible in our country, and crucial. How we go forward on matters of life and love will go to the heart of the kind of community we become.

Were we to accept that some old people can be killed, why not some others? And why restrict it to the old and sick? Why not younger people and those that aren't terminally ill? How about people who are just sick of life? Or people who are unconscious or too young or disabled to consent? It's not that I'm a nervous "slippery-sloper" on this matter. I'm just following the evidence from overseas and the logic of the argument for giving some people a lethal dose.

Euthanasia legislation now being proposed for South Australia only serves to highlight this concern. Under this bill euthanasia would be triggered if a person has "a medical condition" – not necessarily terminal, not necessarily even physical; and if they subjectively regarded their suffering as "unbearable" – and no one may question that judgement. It is the kind of law smart lawyers could "drive a road-train through". There is now talk of a similar bill for Victoria.

Of course, even the most enthusiastic "Dr Death" would not give euthanasia to all-comers. They still would have to make value judgements about which requests were reasonable. But that means we would be asking our doctors to decide who should live and who should die.

That would be a huge change. Having undermined the principles that doctors never kill patients and that our state will not sanction killing the vulnerable, we will have changed what doctors are and what our justice system is.

Perhaps most worryingly, we will have changed how we relate to "unwanted" people. A just and compassionate society surely can find more respectful and loving ways of dealing with suffering at the end of life than killing the suffering person.

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# The logical consequence of a fetishizing of choice

## Netherlands proposes to extend access to ‘euthanasia’ to those who are ‘tired of life’

In 2014, in article entitled ‘Physician-assisted suicide: only as a last resort’, the prominent American bioethicist Arthur Caplan argued that ‘... with adequate protections, adequate controls, adequate oversight, and adequate regulation to make sure that people do not think, “I better do this because I am a burden to others” or “I am going to do this because nothing else out there can help me with my pain, suffering, or depression”, physician assisted suicide ‘may work’. Those are not adequate ethical circumstances to support someone ending his or her own life.’<sup>7</sup>

In October 2016, with two colleagues Willem Lemmens and Trudo Lemmens, Caplan described a proposed extension to the law permitting euthanasia in the Netherlands as a ‘frightening precedent that other nations ought not follow’ and a ‘policy that the Dutch ought to reject’.<sup>8</sup> The extension would enable people who are ‘tired of life’, who feel they have ‘completed’ their lives to request the support of the state to end their lives. As Caplan et al point out, the new proposal ‘clearly sits on a continuum that the Dutch have been sliding down — incredibly — toward full state support for euthanasia on demand’.

Euthanasia in the Netherlands has already been offered to couples who want to die together, people who are disabled and increasingly to people who are just tired of life. These ‘startlingly subjective’ access criteria, coupled with the option to shop for a ‘lenient’ physician, and the almost-non-existent findings of non-compliance appear to make it exceedingly easy to fulfill the *existing* legal criteria.

How, asks Caplan, can one not see the danger of this shift, this ‘*logical consequence of a fetishizing of choice*’? What the Dutch Cabinet proposes may affect people who are lonely and isolated or fear becoming a burden to society. It glosses over the dangerous financial and emotional pressures that might increase once the elderly, particularly those who are disadvantaged, are offered a quick and smooth exit (against the backdrop of cost savings in healthcare).

Broad access to state-sanctioned suicide risks endangering the weak, the fragile, the different and the poor. The authors conclude: ‘*This is not where any society ought to go*’

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<sup>7</sup> ‘Physician-assisted suicide: only as a last resort’, *Medscape*, 24 Sept 2014: [www.medscape.com/viewarticle/831314](http://www.medscape.com/viewarticle/831314); accessed 4<sup>th</sup> December 2016

<sup>8</sup> <http://www.chicagotribune.com/news/opinion/commentary/ct-euthanasia-assisted-suicide-dutch-netherlands-perspec-1018-jm-20161017-story.html> Accessed 17<sup>th</sup> October 2016. *Willem Lemmens is chair of the department of philosophy at the University of Antwerp; Trudo Lemmens is the Dr. William M. Scholl Chair in Health Law and Policy, faculty of law and of the Dalla Lana School of Public Health, University of Toronto; Arthur Caplan is a professor of bioethics at New York University Langone Medical Center.*

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**Thank you**

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