RIGHTS OF THE TERMINALLY ILL (EUTHANASIA LAWS REPEAL) BILL 2008

SUBMISSION – JOHN GREENWELL

SUMMARY

The submission examines first the ethical acceptability of voluntary euthanasia in the community.

As a community we attach significance to three values – respect for life; relief of suffering and personal autonomy. In the situation in which voluntary euthanasia arises, there is acute tension between these three values and typically all three cannot be given unqualified effect. That situation is where a person is subject to unbearable and irreversible suffering from a terminal disease and wants to die.

The position that life is absolute and therefore must displace the other values (where all three cannot be maintained) is derived from the religious belief that that is dictated by God. However,the view that respect for life is *absolute*, solely by virtue of religious belief, is no longer open in a society in which religion is separate from the state.

Nor can unqualified autonomy provide a basis for voluntary euthansia. The community accepts the proscription of assisted suicide. It holds that suicide should not in general be facilitated. But it also accepts voluntary euthanasia. What it requires therefore is that in addition to the exercise of autonomy there should be objective grounds for the person's belief that life has lost its value. Those conditions are satisfied when the condition will result in death and the suffering from it, unbearable and irreversible.

In considering voluntary euthanasia the distinction between ethics and law must be kept in mind. So even if, for the reasons summarised above, it is considered ethical it does not necessarily follow it should be enacted into law. But there is a link. A law will not be effective if it does not accord broadly with the community's ethics. In the case of voluntary euthanasia community support is overwhelming.

Law does depend upon rules, one of which is the prohibition on the taking of life. Community support does presuppose that the general prohibition against the taking of life will not be jeopardised by voluntary euthanasia as an exception to it. There is no basis for this occurring. In the case of voluntary euthanasia the necessary preconditions (of voluntariness, terminality of the condition and of the suffering endured) can all be personally, medically and administratively determined in advance of the event otherwise proscribed. The submission in examining this points by way of contrast to a number of offences where exceptions have been in issue.

The *Rights of the Terminally Ill Act* 1995 is then examined with this in mind and the careful, exact and transparent conditions set out in the legislation are described.

The submission turns to the 'slippery slope' argument.This, unlike the objections previously examined, supposes that if voluntary euthanasia, as an exception to the prohibition on killing, were allowable the moral objection to the taking of life would collapse.

It discusses the suggested analogy of the Euthanasia programme in Hitler's Germany and dismisses it.

Where problems may arise in this connection is where a human inclination or temptation to do an immoral act exists and without a total prohibition there is no clear stopping place before doing or completing it. The submission instanced the absolute interdiction in the use of evidence obtained by torture. All interrogators want to obtain information. To allow them a 'little torture' in the process would undermine the prohibition. But medical practitioners do not ordinarily have any desire to kill. In moral terms it is absurd to suggest the community's distinction between voluntary and involuntary killing would collapse through the introduction of *voluntary* euthanasia.

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Basic submission:

In my submission the Committee should recommend the enactment of the *Rights of the Terminally Ill (Euthanasia Laws Repeal)* Bill 2008.

The *Euthanasia Laws Act* 1997 passed by the Parliament removed the power of the self-governing territories – the Northern Territory, the Australian Capital Territory and Norfolk Island – to enact laws which would permit voluntary euthanasia. In particular, it overrode the Northern Territory *Rights of the Terminally Ill Act 1995*. That Act, which had been enacted by the Northern Territory Legislative Assembly after extended debate, provided for voluntary euthanasia in the Northern Territory. The Commonwealth Act thus rendered inoperative, whether by repeal or suspension, the formally expressed wishes of the people of the Northern Territory. It continues to supersede the self-governing authority of all the democratically elected Territory legislatures on matters covered by the Act .

The enactment of the *Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008* would restore the authority of the legislatures of the territories taken from them by the *Euthanasia Laws Act 1997*. It would give legal effect to the Northern Territory law rendered inoperative by the 1997 Act. In case the Northern Territory law was repealed

by the Commonwealth Act, the Schedule to the Bill would, upon enactment, give it the full force of Commonwealth law by virtue of the territories powers conferred on the Parliament [sect 122 of the Constitution**;**The Northern Territory law would, upon re-enactment, become a Commonwealth law and perfectly valid as such. However, the Northern Territory has been granted self-government. Because of that, the law should be capable of being amended or repealed by the Northern Territory Legislative Assembly. Accordingly, it may be desirable to add to section 2 of Schedule 1, the words "and may be amended or repealed by the Legislative Assembly". Any questions relating to this can be conveniently left to the drafter if the Committee recommends in favour of the Bill]

I turn to examine the question of voluntary euthanasia and the Northern Territory Act although, in doing so, it should not be forgotten that the ultimate question before the Parliament is not whether voluntary euthanasia is good or bad but whether the people of the Northern Territory and of the other self-governing territories are to be deprived of the right to decide upon that through their democratically elected self-governing legislatures.

Ethics – the values of respect for life, relief of suffering and autonomy:

As a community, we attach significance to three values -- respect for life; relief of suffering and respect for individual autonomy.

The situation in which voluntary euthanasia typically occurs involves the intersection of these three values and acute tension between them.

The kind of situation to which I refer is where a person subject to irreversible and unbearable suffering as a result of a terminal illness elects to seek medical assistance to take his or her own life.(In this context 'suffering' extends to the kind of mental and physical disintegration occurring in the case of certain neurological disorders.)

At one extreme it is held that the value of life reflected in the prohibition on the taking of life, displaces the other two values.

This is the position of the Church.

It maintains that in such a situation respect for life involves an unqualified duty to live and, where all three values cannot be maintained, a duty to live should always exclude the other two values. Accordingly, voluntary euthanasia will always be wrong.

The Church says that this is so because

> "believers see in life something greater . . ., namely a gift of God's love, which they are called upon to preserve and make fruitful"... Intentionally causing one's own death, or suicide, is therefore equally wrong as murder; such an action on the part of a person is to be considered as a rejection of God's sovereignty and Loving Plan"[i].

Short of the situation described above, the Church allows palliative care to relieve relievable suffering; it permits treatment by medication and otherwise and, by a curious if benign confusion between 'desire' and 'intention', it will allow such treatment where it is known death will result. Similarly, in a concession to autonomy, it will allow a patient to withdraw medical treatment even though death will be an inevitable consequence. But at the point where suffering is unbearable and unrelievable; where the disease causing it is terminal, where the person suffering makes a clear and voluntary wish to die and where the medical practitioner, knowing that the duty otherwise involved to cure the disease and/or relieve suffering can no longer be effectively carried out, it would forbid voluntary euthanasia.

The religious foundation for this position cannot provide a basis for its acceptance in a secular society in which religious toleration is dependent upon the separation of church and state. Believers may and, of course, will accept it. And the position may be argued and defended on other grounds. But it is no longer capable of being accepted as an absolute value because it has been pronounced as such by the Church. Once it could. Suicide was for long a criminal offence and attempted suicide criminally punishable on grounds similar to those now advanced in respect of voluntary euthanasia.The religious basis for this was accepted as a self-sufficient justification. This is no longer so.

This does not affect the proposition that respect for life and the consequent prohibition on taking it is a critical community value in Australia and in the territories. It is only that it is no longer absolute.

In his *The Sanctity of Life and the Criminal Law*, Glanville Williams wrote:

> It is good that men should feel a horror of taking human life, but in a rational judgement the quality of the life must be considered. The absolute interdiction of suicide and euthanasia involves the impossible assertion that every life, no matter what its quality or circumstances, is worth living and *obligatory* to be lived. This assertion of the value of mere existence, in the absence of all the activities that give meaning to life, and in the face of the disintegration of personality that so often follows from prolonged agony, will not stand scrutiny[ii].

Glanville Williams accurately describes a situation where through pain and suffering life has lost so much of its essential qualities that it is no longer "obligatory to be lived ".The most recent example is the reported case in France of Chantal Sebire suffering from a rare, incurable and excruciatingly painful tumour of the sinuses which made her nose and eyelids swell to several times their normal size.

Nevertheless, no matter how great the suffering or how bad the quality of life, euthanasia, to be ethically justifiable, must be voluntary. To go on living in such a situation or to choose death should be an autonomous choice. Autonomy is in fact an important link with the value of life. Once the objective grounds of irreversible

suffering are established it rests upon the suffering human person to determine whether his or her life has lost its ‘meaning’.

An opposing view and one at the furthest extreme from that advanced by the Church is that one should at all times give paramountcy to autonomy of choice. It is claimed that each person has a right to die and that the right to seek assistance to give it effect, is only a natural and derivative extension of that right. Your life is your own. Nobody can dictate when you can cease to maintain it. The logic of this view is that ‘voluntary euthanasia’ would be permissible whenever it is freely chosen by an adult person irrespective of circumstances. The right is not, on this view, contingent upon the existence of suffering, diminished quality of life or any other objective consideration.

It is convenient to examine this view in the context of our law of suicide and assisted suicide. At present our law does not proscribe suicide or attempted suicide but it does forbid assisted suicide. The question arises: why, if autonomy is to be accorded in the case of suicide, it is not accorded in the case of assistance to do it.

One practical reason for the distinction is the difficulty of effective enforcement against a suicide and against a person attempting it. In the case of attempted suicide there were evidential difficulties in distinguishing between a genuine attempt and a gesture.

In my submission there is a more fundamental objection. The community has a collective interest in the value of life and expends great effort in preserving it. To allow unconditional, assisted suicide would involve the value of autonomy displacing entirely the value which the community attaches to human life and its preservation. It would involve that a person could at any time and for any reason not merely suicide but lawfully seek assistance to effect it. It is one thing to permit, or at least, not proscribe suicide; it is another to facilitate its occurrence by allowing it to be unconditionally assisted. How very different is the case of voluntary euthanasia where the condition of autonomy is satisfied but there are, in addition, objective grounds justifying assistance.

Where there is great suffering and the individual life in question has become beyond endurance, the respect owed to life and the ordinary insistence upon it being maintained is reduced and the other two ethical claims become more significant. At a certain point in this moral trajectory the claim of autonomy and relief from suffering supersede the duty to live which would otherwise apply. That point is reached when the suffering is unbearable and irreversible. In such a case, if the condition is also terminal, there is no incompatibility with the values of the medical profession in providing assistance to end life as the professional duty is not only to preserve life - which, on this supposition, cannot be given effect - but to relieve suffering.

Many legislative proposals require that the disease or other affliction of the sufferer be ‘terminal’. Unbearable suffering, where death is the only means of ending it, might result from a disease which is not terminal. It may be said therefore that terminality is not essential in *principle* in the case of a patient with unbearable suffering who has clearly expressed his or her wish to die. It is though, in practical terms, easier to accept that an end of life decision is voluntary if the disease is known to be terminal. But in the case of the medical practitioner who is assisting, terminality is more than

that. It is essential. This is so because the duty ordinarily imposed upon a doctor to preserve life is only nullified by the inevitability of death and therefore of the ability to preserve life. The only medical duty at that point is to relieve suffering within the limits of autonomy.

A question arises whether the irreversibility and unbearableness of suffering must in fact exist to justify voluntary euthanasia morally or is it sufficient for the person to simply believe that they do? It is not necessary to be caught between these two extremes. What is required is that the person honestly and reasonably believes those conditions exist. Respect for the value of life requires the person to go beyond a mere subjective belief that life has lost its quality and meaning. Reasonableness of belief which mandates that the belief has objective and, in practical terms, medical grounds to support it, is required in addition to genuineness of belief.

Accordingly - and to sum up on the ethical issue - it is ethical for an adult sufferer freely to seek assistance from a medical practitioner to die where the suffering is unbearable and the sufferer has a reasonable and honest belief it is irreversible: and it is ethical for a medical practitioner to provide that assistance where (a) he or she is willing to do so and (b) if the disease or other affliction causing the suffering is terminal and in the medical practitioner's professional opinion that suffering is irreversible, and (c) claims by the patient that it is unbearable are consistent with the disease or affliction suffered.

Law and Ethics – contrast and similarities – significance of community attitudes – voluntary euthanasia as an exception:

Ethics and Law (which has not so far been considered) are not coterminous. It would thus not be illogical to hold voluntary euthanasia to be ethical but should not be enacted into law. When we move from ethics to law we are in a sense in a different area: we are inescapably controlled by 'rule' as distinct from ethical principle. When we apply ethical principles and the principles are in tension there is considerable scope for individualisation in forming our ethical judgement. Thus, we can have regard generally to a person's capacity for mature judgement notwithstanding his or her precise age. But once the issue is one of law we must have a fixed rule and so we provide say that only those over the age of 18 are deemed adult and have the autonomy which that implies. This does not mean there is no scope for individualisation in law but it is more circumscribed. Typically it takes the form of an exception to the general rule in order to meet some social need or demand derogating from that rule.

While law and ethics are not coterminous they do intersect. Law must be consistent with the minimum ethics of the community. Too low it will fall into disrepute. Too high it will be disobeyed. The classic instance of the latter was the collapse of prohibition in the United States.

What then is the community's view of the ethics of voluntary euthanasia? A majority view in its favour has been recorded in innumerable Polls in most western countries over an extended period. The majorities in these Polls are very substantial. Indeed the steadily increasing majority during the last half a century only adds weight to the conclusion one would ordinarily draw from the Polls individually.

What has been said though does not represent the entire picture of community attitudes to voluntary euthanasia and its interrelationship with the law. Voluntary euthanasia is an exception to a general rule. That is the rule of the criminal law forbidding the taking of life reflected in the homicide offences. It is reasonably clear that this general rule commands universal community assent. In other words, whilst denial of voluntary euthanasia as such would be to disregard the broad community position, the community does see voluntary euthanasia as an *exception* and would not support it if its exceptional character could not be maintained.

If an exception to a general rule is not 'contained' in the practical administration of justice it will tend to undermine the general rule. And where because of this it is not thought possible to maintain the primary rule the exception will not be introduced into the law. This will be so notwithstanding it is acknowledged that there may be cases where the general rule, without an exception, may work an injustice. An example of this is provocation which is not available as a defence to a charge of assault and would, at common law, only reduce murder to manslaughter. Another example is that of duress or necessity which is not allowable as a defence to murder. And yet we might concede there could be cases of provocation or necessity where the 'murder' is morally excusable: and the law in denying these defences does not in the abstract question that. The law excludes these defences because they cannot in practice be restricted, and so would undermine the *enforcement* of the primary rule against the taking of life or preventing assaults. In the case of both provocation and necessity the Courts may take account of them in the penalty imposed.

The question then, having reached the position that voluntary euthanasia is ethically justified and embodies the moral feelings of the community, is whether it can, if embodied in law, be given effect in a practical sense by the medical profession, police and the courts without expanding so as to jeopardise enforcement of the primary rule against taking life.

We must define this issue more precisely. It is not in this instance a question of contrasting a law forbidding the taking of human life which is administratively and coercively effective to prevent euthanasia, voluntary or otherwise, with a proposed law which would permit it. That is not the case. The issue is whether a proposed law which expressly admits but regulates voluntary euthanasia is to be allowed as against an existing law which purports to prohibit voluntary euthanasia but is frequently not observed and even less frequently enforced.

As long ago as 1994, the Baume inquiry found that one in five doctors in New South Wales and the Australian Capital Territory admitted to having practised euthanasia. Comparable findings have been made in Great Britain. These only confirm anecdotal evidence. Of equal importance has been the absence of any enforcement action or even any expression of public concern. In March 1995 seven Melbourne doctors

wrote openly to the Premier of Victoria admitting they had broken the law and calling for it to be changed. In their open letter they said: "we do this because we believe passionately that this state's law on assisted suicide is wrong.[iii]" No prosecutions eventuated.

The existing law thus notably fails to uphold the single value it seeks to embody.

We can thus proceed to examine in this context whether the legislative introduction of voluntary euthanasia can be given effect without prejudicing the rule against the taking of life beyond the grounds of exception I have mentioned.

Unlike the exceptions to criminal offences mentioned above, in which legislative and administrative controls would be inappropriate to their enforcement, legislative and administrative controls are available in relation to voluntary euthanasia. In the case of exceptions to those offences – say provocation – the condition of the exception takes place concurrently with the otherwise proscribed act – intentional killing. In the case of voluntary euthanasia all the conditions essential to its validity take place in advance of the euthanasia. Each may be subject to specified legal and administrative requirements which are examinable and enforceable to guarantee voluntariness, the extent of suffering and terminality. What is imperative to achieve this though is transparency – so sadly lacking under the existing law. It is necessary therefore that there be an objective, open, medical assessment of the terminality of the condition suffered by the patient and that unbearableness of suffering is consistent with the condition. Next is a requirement that the likely future progression of the condition, including the availability of palliative care, should have been fully explained and a record made of the patient's understanding of the explanation. Then it is for the patient to say - in accordance with the principle of autonomy - whether, in the light of what he or she has been told, he or she wants assistance to die. Thus, although the medical practitioner is to describe and explain the medical condition and the quality of life the patient may expect, it is for the patient to decide whether to make a request for assistance. In accordance with the need for certainty and transparency the decision to seek assistance must be in writing and recorded. Finally, there must be a 'cooling-off' period to enable the patient to reflect on the decision. And it is entirely appropriate for the legislation to ensure that the decision has not been the product of clinical depression.

The distinguishing feature applying to doctors who are at present prepared to carry out euthanasia contrary to existing law is the almost complete absence of control over the way the euthanasia is carried out.

The doctor is not, of course, restricted by any prescribed procedures nor by the need to keep records because the euthanasia being undertaken is legally prohibited. It is therefore clear that medical practitioners carrying out euthanasia must do so in secret. He or she would only face the danger of prosecution if the authorities were to become aware. Such a doctor undertaking euthanasia would be unlikely to seek a second opinion on whether the patient's condition was as dire as he or she believed. There would be even less likelihood of seeking the opinion of a psychiatrist. There would not necessarily be a period of delay -- a 'cooling off' period – during which the patient could reflect upon any wish he or she may have expressed to die. If we consider the essential element of patient-autonomy, it may be assumed that the doctor

would have sought the patient's decision but it would be fortuitous if there were any deliberate and permanent expression of it. What would never be known, at least publicly, is what advice was given by the doctor to the patient. This situation opens up the possibility of undue susceptibility of the doctor to the family of the patient about which, except by chance, we would never know.

Medical practitioners ready to breach the law are mostly activated by compassion. But it does mean that this is necessarily being done in an unregulated way. The danger in these circumstances is that doctors influenced by compassion will give undue weight to relief of suffering at the expense of autonomy. The converse case of a medical practitioner over-emphasising autonomy is also possible. He or she will not attach sufficient weight to the need for unbearableness and terminality and may too readily accede to a request that has not been fully considered and is not sufficiently based upon an objective assessment of the suffering.

The Northern Territory Rights of the Terminally Ill Act 1995:

The *Northern Territory Rights of the Terminally Ill Act* (the Act) represents a model which in legislative terms would ensure that voluntary euthanasia does not extend beyond its intended effect and limitations. As the Senate Committee called upon to examine it in 1997, described it:

> The Act contains a large number of provisions intended to ensure that the patient, all the medical personnel and any nursing home involved are all voluntary participants in the determination of that person's life. The Act also requires that a broad range of factors must have been considered before reaching and implementing the decision to terminate the patient's life. It requires the participation of at least three medical practitioners. It also requires that the patient be given information on the palliative care that might be available[iv].

The Northern Territory Act sets out a readily comprehensible working document for medical and hospital personnel and for the police. It is capable of clear interpretation in a Court of Law.

It provides:

The patient

- must be at least 18 years old, terminally ill and suffering from pain, suffering and/or distress which the patient finds unacceptable;
- must be of sound mind and want to die freely, voluntarily and after due consideration (as to which a medical practitioner must be satisfied);
- may sign a certificate requesting to be assisted to die which he or she may withdraw at any time;

A medical practitioner (having five years continuous experience) may assist the patient to die if he or she is satisfied on reasonable grounds:-

- the patient is terminally ill ;
- there is no hope of effecting cure;

- the illness is causing the patient severe pain or suffering or distress;
- no palliative care options are reasonably available to the patient to alleviate the pain and suffering to levels acceptable to the patient;
- the patient is of sound mind and wants to die, freely, voluntarily and after due consideration;
- no less than seven days has passed between the patient indicating to the medical practitioner a wish to die and signing a certificate of request;
- the medical practitioner must witness the patient's signature on the certificate of request;
- no less than 48 hours have passed since the medical practitioner has completed and signed the certificate;
- the medical practitioner will gain no financial advantage (other than payment for services) from the death of the patient;
- a second medical practitioner experienced in the treating the illness involved and independent of the first medical practitioner has confirmed the first medical practitioner's opinion about the nature and seriousness of the illness
- and a qualified psychiatrist must be satisfied the patient is not suffering from treatable depression;

The question of a 'slippery slope':

There is a further question which can now be considered in the light of the legislative scheme set out. It is said that if voluntary euthanasia were introduced, the legal prohibition on the taking life would begin upon a 'slippery slope' to which there is no foreseeable stopping place. This bears a superficial similarity to the argument that, as an exception, voluntary euthanasia would undermine enforcement of the general rule. But there we were concerned with the practical, administrative and even purely legal difficulties in maintaining an exception due to the pressures to expand it. Here the fear is that the moral value against the taking of life will collapse. The taking of life would become acceptable ethically.

Discussion of the slippery slope argument has been distorted by the suggestion that the outcome of voluntary euthanasia is exemplified by the Euthanasia Programme introduced by Hitler in Nazi Germany.

There are fundamental differences. Hitler's Programme was never voluntary and never purported to be. Under it euthanasia was compulsory for the physically or intellectually disabled. It repudiated any notion of autonomy. It was not based upon the relief of suffering. It is difficult to conceive how any realistic analogy can be drawn between a programme to compulsorily eliminate the socially unproductive and voluntary euthanasia, in which autonomy and compassion are the critical values; nor how the latter could or would gradually grow into the former.

In his final comments upon the *Nazi analogy and Contemporary Debates*, Michael Burleigh wrote:

> Except in a few cases involving the parents of handicapped infants, even indirect consent was not in evidence, although such policies banked on widespread indifference or silent collusion among the population at large.

> Whatever their rhetoric, the Nazi doctors themselves were not motivated by compassion for suffering individuals, since their modus operandi involved making decisions on the basis of forms rather than people, while those who killed were in no way familiar with their victims[v]

We may thus disregard the distraction of the Nazi analogy in considering the 'slippery slope'.

Proponents of the 'slippery slope' argument proceed upon the basis that any exception to a primary rule will undermine the value embodied in it. The community is, so to speak, pivoted upon a moral slope and, should there be any exception, it will be precipitated towards a collapsing moral value and, in this case, the acceptance of murder.

Plainly this cannot be true of all exceptions or the criminal law would be a catalogue of absolutes. It is true that pressures may be brought upon a moral value where there are temptations to break the primary rule and there is no clear moral 'stopping place'. Thus the prohibition against the use of evidence obtained by torture is absolute. The temptation upon interrogating officials to use coercion is considerable. It is easy to see that any relaxation in the primary rule so as to allow admission of evidence obtained by a 'little torture' would progressively diminish the moral objection to the forensic use of coerced evidence.

In the case of voluntary euthanasia there is a clear moral 'stopping place'. The essence of voluntary euthanasia is that it is voluntary. That is an indispensable and definable condition (as mandated by the Northern Territory legislation). The medical profession shares the general abhorrence of the community towards murder. There is no reason to suppose it seeks to aid Goneril-like daughters in the disposition of ageing parents. As passionately stated by the seven doctors in their Open letter to the Victorian Premier in *The Age*: "We respect life. All our professional training defines that respect". Rather, it is the continued absolute but ineffectively enforced prohibition under the present law which is more likely to undermine the respect for life than any metaphorical slippery slope.

In the past few years a non-legislative approach has been advanced to promote the availability of a pill designed to provide a pain-free death by ingesting it at a time of the person's choosing.

This proposal is not in issue here.

It may be remarked though that it was entirely predictable that with the overriding of the principled legislation embodied in the *Rights of the Terminally Ill Act* and supported by the people both in the Northern Territory and Australia as a whole, that desperate human beings would endeavour to circumvent the existing prohibition.

John Greenwell

[i] *Sacred Congregation for the Doctrine of the Faith:; Declaration on Euthanasia*, Rome 5 May 1980, St Pauls Publications, Sydney, 1980
[ii] William G, *The Sanctity of Life and the Criminal Law*, Faber & Faber, London , 1958 pp 281-2 (Italics added)
[iii] *The Age*, Melbourne, 25 March, 1995
[iv] The Rights of the Terminally Ill Act 1995 was enacted by the Legislative Assembly of the Northern territory in May 1995 and came into force on the 1st July 1996. This summary comes from Chapter 2, page 5 of the Senate Legal and Constitutional Committee of the Commonwealth Euthanasia Laws Act 1996.
[v] Burleigh, M "Nazi analogy and Contemporary Debates" in Ethics and Extermination, Cambridge University Press, Cambridge, 1977 p 151