Committee Secretary
Senate Standing Committee on Legal and Constitutional affairs
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

2 April 2008

Dear Sir,

Submission from the Life, Marriage and Family Centre, Catholic Archdiocese of Sydney to the Inquiry into the Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008

In my position as Director of the Life, Marriage and Family Centre, and drawing on my experience as a family and parent advocate and bioethicist, I wish to forward this submission on behalf of the Life, Marriage and Family Centre, Catholic Archdiocese of Sydney.

The Life, Marriage and Family Centre is an agency of the Catholic Archdiocese of Sydney and has been established to extend the research, policy, educational and pastoral activities the Church undertakes with respect to life, marriage and family issues. Currently there are some 589, 000 Catholics in the Archdiocese of Sydney, constituting 32.3% of the general population living within the geographical boundaries of the diocese. Over one million Catholics live in the greater Sydney area and there are approximately 5.1 million Catholics nationally.

The Catholic Church has a great and ongoing tradition of caring for the ill and dying and for their families. Catholic agencies have long dedicated significant resources to provide hospices and quality palliative care and we continue to be involved as a significant non-government provider of these important services for the wider community.

Catholics hold strong beliefs about the dignity of the human person, especially those persons in vulnerable circumstances. We maintain that proper social relationships call us to always strive for the good of every person. Sometimes this may require a radical self-giving and a willingness to generously respond with support for those who are suffering.

In such situations a proper response is one of solidarity which encompasses care for the sufferer rather than their deliberate killing, with or without their request. A key element of respecting human dignity is the need to respect and value human bodily life. Hence, the individual and social resolve to respect all human life and to never regard a life as lacking worth is essential for a society that wishes to protect and equally value all of its citizens. Within this context, we are very supportive of legislation which does not allow states or territories to sanction processes which by deliberate act or omission, permit the intentional killing of human beings.

Provisions of the Bill

The Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008 seeks to allow jurisdictions within Australia to enact legislation which permit the deliberate killing of Australian citizens. Specifically, the Bill seeks to allow the ready application of the provisions of the Northern Territory Rights of the Terminally Ill Act 1995.

Comments

1. **Some important distinctions.** We regard euthanasia as any deliberate act or omission which puts an end to a patient's life with the purpose of ending their suffering. Physician Assisted Suicide (PAS) is regarded as the death of a patient as a direct consequence of assistance given by a doctor. Currently the Netherlands and Belgium have legalised euthanasia while PAS is legal in the Netherlands and Oregon, USA. We do not regard palliative care or the refusal of extraordinary or burdensome treatment as the equivalent of euthanasia or PAS.

2. **Current options respect human dignity.** While respect for the inviolability of human life prohibits intentional killing, it does not follow that life must be preserved 'at all costs'. For example, burdensome or overly invasive treatment might reasonably be refused by a competent person, particularly where such treatment is likely to be futile. The refusal of such treatment by a patient in these circumstances is not the same as suicide. However, basic nutrition and hydration (food and water) should always be provided and such care should not be regarded as extraordinary or burdensome treatment. It may also be permissible to accept a foreseen but unintended side-effect such as the possible shortening of life, where the unintended side-effect is balanced by the intended effect of relieving pain. Every patient is entitled to adequate pain relief to enable them to attend to their spiritual, moral and family duties. However, the intention must always be to provide care for the patient, not to kill them. We maintain a fundamental distinction: seeing a life as having no value and killing someone is *not* equivalent to continuing to value a patient's life while foreseeing that their life may be shortened through changes to a treatment regime. As such, the current provisions within Australia under which proper palliative care can be administered to the suffering and dying are consistent with respect for their dignity as persons.

3. **Corrupting the role of doctors and decreasing individual autonomy.** If our society accepts that doctors 'may now take human life in certain circumstances', medical practitioners will be deliberately engaged as purveyors of death. The 'easy death' experience in the Netherlands has found that over 50% of surveyed doctors now think it appropriate to suggest euthanasia to patients[1]. Legalised euthanasia significantly alters the nature of the doctor-patient relationship and greatly diminishes the level of trust which is so important for the effective practice of medicine. Indeed, if euthanasia became legal medical training would require that doctors be taught how to kill. Once the medical prohibition on deliberate killing is broken, it would become increasingly easy for doctors to euthanasise the incapacitated, the emotionally distressed and the disabled newborn. As Palliative Care specialists in the UK commented, "Euthanasia, once accepted, is uncontrollable for philosophical, logical and practical reasons. Patients will certainly die without and against their wishes if any such legislation is introduced"[2] Surveys in the Netherlands in 1995 and 2001 reveal that 9% of all neonatal deaths follow the administration of drugs which hasten death and that 2.7% of deaths of children between 1 and 17 years of age are due to euthanasia[3]. Defenders of the Groningen Protocol on infant euthanasia already maintain that it applies to infants who 'are in no danger of dying' and that the 'unbearable suffering' criterion could be applied on the basis of an infant's perceived future state of health[4]. Such enthusiasm for engaging health professionals and medical facilities in the killing of vulnerable infants is extremely disturbing.

4. **The effect of the fear of being a burden.** Personal autonomy is also significantly undermined where the legal acceptance of euthanasia serves as a platform for the cultural unacceptability of being a burden to others. In Oregon in 1998 after PAS was legalised, 12% of those requesting PAS cited their desire not to be a burden to others as one of their reasons. By 2000, nearly two thirds (63%) of those who died through PAS stated that considerations of not wanting to be a burden to family or caregivers as a main reason[5]. It is also easier and cheaper to kill a patient than to provide palliative care. It may be of some relevance that a report of end-of-life care in Oregon hospitals awarded that State a Grade E for how well it cared for patients in such situations.[6]. Good palliative care can become a

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[1] P.J.van der Maas, J.J.M.van Delden and L. Pijnenborg, *Euthanasia and Other Medical Decisions Concerning the End of Life* (1992), pp.101-2.

[2] Statement by the UK Association for Palliative Medicine & the National Council for Hospice and Specialist Palliative Care Services on proposals to legalize euthanasia and PAS. 2003

[3] Vrakking A et al. Medical end-of-life decisions made for neonates and infants in the Netherlands. 1995–2001. Lancet, 2005; 365: 1329-1331 Vrakking A et al. Medical end-of-life decisions for children in the Netherlands. *Archives of Pediatrics & Adolescent Medicine* 2005; 159: 802-9.

[4] H. Lindemann and M. Verkerk, *The Hastings Center Report* ,"Ending the Life of a Newborn: The Groningen Protocol", Jan-Feb [2008]: 42-51.

[5] Sullivan AD et al. Legalized physician-assisted suicide in Oregon, 1998-2000. *New England Journal of Medicine* 2001; 344: 605-607.

[6] Baroness Finlay, Professor of Palliative Care in a debate in the UK House of Lords, *Hansard*; Oct. 10th, 2005, column 23f as detailed in *Euthanasia and Assisted Suicide: A Joint Statement by Doctors and Lawyers*, 26 Oct 2005

secondary concern and less likely to be able to be accessed by those patients not wanting to be euthanised. Legalisation, over time, affects hospital practice and societal expectations, ultimately resulting in undue pressure on patients to not "over burden" family, medical staff and or resources. These subtle, or not so subtle forms of persuasion ultimately diminish a person's freedom and personal choice. Irrespective of 'safeguards', voluntary euthanasia inevitably leads to involuntary or non-voluntary euthanasia – the killing of human beings who have not consented, or who are unable to consent to being killed.

5. **The transient nature of the wish to die.** The wish to die can often be an expression of depression, pain or poor symptom control rather than a sincere desire to be killed. In Oregon, where PAS is legal, nearly half of those initially requesting PAS changed their minds after treatment for pain or depression commenced or referral to a hospice was undertaken. Where no active symptom control commenced, only 15% changed their minds[7]. The close relationship between depression and the wish to die led one study to conclude: 'The desire for death in terminally ill patients is closely associated with clinical depression — a potentially treatable condition — and can also decrease over time. Informed debate about euthanasia should recognize the importance of psychiatric considerations, as well as the inherent transience of many patients' expressed desire to die'[8]. It is normal for vulnerable persons in challenging situations to seek a reduction in their level of pain and psychological distress. Society has a duty to protect them and to ensure that they receive the level of support that they need. It is not society's role to kill them or to assist in their killing.

6. **Internal contradictions and the 'slippery slope".** The emphasis on a patient's wish to die rather than receive palliative care is often found in euthanasia legislation such as the Rights of the Terminally Ill Act (NT) 1995. In this Act the criterion of an expressed desire to be killed is combined with the requirement for the patient to be deemed terminally ill. However, if a patient's suffering is deemed 'unacceptable' by the patient or by others, why does it matter whether this suffering is due to a terminal illness or not? The criterion of 'unacceptable suffering' is either sufficient or not since a non-terminal illness could cause an equivalent amount of distress. If it is sufficient, as euthanasia advocates appear to imply, then there is a broad premise for an ever-widening range of individuals to be killed provided they satisfy the highly subjective 'unacceptable suffering' criterion. Indeed, the argument which calls for the 'caring' State to euthanise those unfortunate persons usually incapable of articulating a choice, such as the

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[7] Ganzini L et al. Physicians' experiences with the Oregon Death with Dignity Act. *New England Journal of Medicine* 2000; 342: 557-63.
[8] Chochinov HM et al. Desire for death in the terminally ill. *American Journal of Psychiatry*. 1995; 152: 1185-91

chronically ill elderly and the mentally handicapped, is given further momentum[9]. As one researcher commented in a review of the Dutch experience, 'When, as the 1990 and 1995 studies document, 59% of Dutch physicians do not report their cases of assisted suicide and euthanasia, when more than 50% feel free to suggest euthanasia to their patients, and when 25% admit to ending patients' lives without the patient's consent, it is clear that terminally ill patients are not adequately protected'[10]. Perhaps most worrisome of all is the suggestion by the authors of these two Dutch studies that it is now the responsibility of the *patient* to avoid termination by specifying clearly and in advance, their desire *not* to be killed[11].

7. **The disproportionate effect of small assemblies.** The Bill for an Act to repeal the Euthanasia Laws Act 1997 has as its object to recognize the rights of the Northern Territory, the ACT and Norfolk Island to legislate to permit euthanasia for the terminally ill. These assemblies have a relatively small members of members (ie. 25 in the NT and 17 in the ACT) and have no upper house of review. It is not in the interest of our nation to have such small legislatures make decisions that would permit and potentially encourage Australian citizens to kill themselves or to have themselves killed.

Summary

In conclusion, the legalisation of voluntary euthanasia would have damaging private and public effects. It would say that some patients' lives have no value. In addition, it would be corrupting of a profession traditionally oriented to healing by involving doctors and nurses in the deliberate killing of their patients. PAS would also be destructive of the trust so essential for the effective operation of the doctor-patient relationship in the wider community. Legalised euthanasia would espouse the cultural unacceptability of being a 'burden to others' and place vulnerable groups at particular risk. The functional drive for efficiency would inevitably give further momentum to pursue the 'quick fix' by disposing of those patients who place significant demands on hospital resources. Euthanasia would become the cheaper and preferred option and as overseas experience has shown, many patients would be killed without request or consent. The suicidal would be affirmed in their assessment of having a life 'not worth living' and increasing numbers of others

[9] By way of example, the current leader of the Belgium Liberals, a key party in the Belgium government coalition wants to extend the benefits of doctor-assisted suicide to teenagers and has also pledged to provide euthanasia for people who qualify for euthanasia but are so demented that they are incapable of asking for it. *Bioedge Newsletter*, Wednesday 2 April 2008.

[10] H.Hendin, 'The Dutch Experience', *Issues in Law and Medicine* 2002, Vol. 17, No. 3, p.234.

[11] G. van der Wal and P.J. van der Maas, 'Euthanasie en andere medische beslissingen rond het levenseinde: De Praktijk en de Meldingsprocedure [Euthanasia and Other Medical Decisions Concerning the End of Life: The Practice and the Notification Procedure] (The Hague, 1996), p.237; G. van der Wal, A. van der Heide, B.D. Onwuteaka-Philipsen & P.J. van der Maas, *Medische Besluitvorming aan het einde van het leven: De prektijk en de toetsing procedure [Medical Decisionmaking at the End of Life: The Practice and the Review and Verification Procedure*] (Utrecht, 2003), p.201

would cease to see their own lives as worthwhile. When laws change, social perceptions and norms change with them and the resultant effects are felt by everybody.

We maintain that all human life has value and that the life of every person possesses inherent and equal dignity. This is an important principle for the security and safety of us all. The accumulated wisdom of all successful cultures and societies tells us that the most advantageous way to nurture the understanding that all human life is precious and of equal worth is to maintain the prohibition on killing. Human bodily life has intrinsic value and respect for each human life is integral to respect for human dignity. When we allow individuals or groups to kill, with or without a subject's consent, we particularly heighten the risk to those vulnerable persons who are infirmed, elderly or disabled.

Thank you for the opportunity to make a submission to the Secretariat undertaking this review. I would be happy to meet with any relevant persons to discuss the issue outlined above should that be useful. I can be contacted on 02 93905368 or by email on marriageandfamily@sydney.catholic.org.au

Yours sincerely,

Christopher Meney
Director, Life, Marriage and Family Centre
on behalf of the Catholic Archdiocese of Sydney,