

Submission to the Senate Legal & Constitutional Affairs Committee

Inquiry into the ‘Rights of the Terminally Ill (Euthanasia Laws Repeal) Bill 2008’

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Introduction

Part 1

This Bill lacks ‘legislative proportion’:

- **A small Territory legislature should not be allowed to pass such radical laws with national impact.**

Part 2

This Bill lacks ‘moral proportion’:

- **The Bill, in its title and effect, lacks balance and proportion: it only asserts the ‘rights of the terminally ill’ and fails to consider the oppressive consequences of euthanasia on the most vulnerable members of society.**

Part 3

Medical considerations.

Conclusion:

Euthanasia brings increased ‘rights’ to some, but subtle oppression to others. Any law which fails to protect the most vulnerable is bad law. The Northern Territory *ROTI Act* is bad law and should not be reactivated. Therefore the Bill before the Committee should be rejected.

Appendix:

Clarification of ‘euthanasia’ and ‘assisted suicide’:

Part 1:

This Bill lacks ‘legislative proportion’:

- **A small Territory legislature should not be allowed to pass such radical laws with national impact.**

Senator Bob Brown’s Private Member’s Bill would have the effect of reactivating the Northern Territory *Rights of the Terminally Ill (ROTI) Act* which had been rejected as unjust and unsafe by Federal Parliament.

The Bill before the Committee lacks any sense of ‘legislative proportion’ in that it would allow a tiny Territory legislature to pass a radical law that no State legislature sees fit to pass.

A legislature which lacks the checks and balances of a house of review, with a constituency comparable to the Toowoomba Regional Council, is not a substantial enough vehicle to carry such weighty legislation.

The existing Federal legislation is not obstructing the valid expression of the will of the Australian people on euthanasia – State parliaments are free to consider euthanasia, which they do from time to time, and wisely they continue to reject it. But a matter of such magnitude, being so radical a departure from settled law, cannot validly be introduced by a subsidiary legislature representing only 1% of the nation. Especially since the other 99% of the nation will be affected by such a law: euthanasia under the ROTI Act has no residency test, and would be open to the entire Australian population.

Conclusion:

Senator Brown’s Bill should be rejected and the current limitation on Territory powers left unchanged, so that any legislation on euthanasia can be considered in the appropriately substantial setting of a major State legislature.

Part 2:

This Bill lacks ‘moral proportion’:

- **The Bill, in its title and effect, only asserts the ‘rights of the terminally ill’ and fails to consider the oppressive consequences of euthanasia on the most vulnerable members of society.**

Most importantly, Senator Brown’s proposal lacks moral proportion, focusing on the parochial issue of Territory rights, and the small-picture scenario of a patient’s “right” to be put to death. By contrast, the Federal Parliament’s focus in 1997 was on the big-picture issue of justice - whether laws permitting euthanasia are intrinsically unjust and corrupting of social relationships.

They are, and that is why the Northern Territory law must not be reactivated.

The Brown Bill can be seen as unbalanced and lacking serious engagement with the wider issues of justice when we look to the central conclusions on euthanasia by the Australian Parliament, as well as other major world enquiries into euthanasia. Always these reports *balance* the deeply felt concern for the terminal suffering of our loved ones, with the serious issues of corruption of law and social relationships that would result from legislators setting up the social machinery of mercy killing.

May I illustrate this with reference to two comments of the majority report of the Legal and Constitutional Legislation Committee in its 1996 Report.

Reference 1.

The majority of Senators joined their central concerns to those of other international enquiries:

We share the views expressed by members of the House of Lords Select Committee, the Canadian Special Select Committee and the New York State Task Force that laws relating to euthanasia are unwise and dangerous public policy. Such laws pose profound risks to many individuals who are ill and vulnerable. In particular we share the view of the House of Lords Select Committee on Medical Ethics which held that: ‘The prohibition of intentional killing is the cornerstone of law and of social relationships. It protects each one of us impartially... We do not wish that protection to be diminished.’

Of these reports, the most illuminating remains the United Kingdom House of Lords enquiry in 1993 (and notably, the recent vote in the House of Lords against euthanasia supports the earlier 1993 enquiry). Revisiting this richly humane and wise report will help the Committee judge how inadequate Senator Brown’s Bill is, which only gives attention to “rights” and not to wider social duties to protect vulnerable and disadvantaged people.

It is highly significant that the majority of the House of Lords Select Committee's members were previously on the record as favouring legalised euthanasia, including the Chairman, Lord Walton of Detchant, a neurologist who had been Medical Consultant to the Voluntary Euthanasia Society. The Committee's reflections on this question of the dying or debilitated patient showed their personal sympathy for the plight of such people: Many of us have had experience of relatives or friends whose dying days or weeks were less than peaceful or uplifting. Or whose final states of life were so disfigured that the loved one seemed already lost to us. Our thinking must inevitably be coloured by such experience. The accounts we received from individual members of the public about such experiences were particularly moving, as were the letters from those themselves who longed for the release of an early death. Our thinking must also be coloured by the wish of every individual for a peaceful and easy death, without prolonged suffering, and by a reluctance to contemplate the possibility of severe dementia or dependence.

It is remarkable that a Committee which was predisposed to support mercy killing, concluded, after extensive research and public discussion, and a visit to Holland, by strongly opposing any such move. Dr Luke Gormally Director of the Linacre Centre for Health Care Ethics in London saw in this transformation evidence of the Committee's impartiality:

This seems to me to mark a difference between true statesmen and short-sighted politicians, that the Committee was unwilling to allow such personal and emotive experiences to control public policy. It is not that they were without compassion,

but they were convinced that we need to look for creative responses to illness, suffering and dying and be loathe to embrace destructive ones.”

The UK Committee stressed the prime importance of creative responses to illness:

There is good evidence that, through the outstanding achievements of those who work in the field of palliative care, the pain and distress of terminal illness can be adequately relieved in the vast majority of cases. With the necessary political will, such care could be made available to all who could benefit from it.

We can note from the House of Lords conclusions that even people with a predisposition to support euthanasia can come to accept that the wiser and more humanly creative path to take is to strive for more effective and more holistic palliative care.

But what were the "big-picture" considerations which brought about such a significant change of heart and mind? The Select Committee's central concern was about an injustice inherent in the social establishment of euthanasia. In short, they perceived a new and subtle form of oppression:

It would be next to impossible to ensure that all acts of euthanasia were truly voluntary. We are concerned that vulnerable people - the elderly, lonely, sick or distressed - would feel pressure, whether real or imagined, to request early death. We believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.¹

That is the heart of the matter - this insidious pressure on the vulnerable to comply with social expectations of euthanasia. This subtle and unavoidable oppression of the elderly, lonely, sick or distressed is the corruption we did not need to have.

The UK Committee was able (unlike Senator Brown's Bill) to balance the claims of individual claims against the bigger picture of the corruption of basic law and our relationships with the 'unbeautiful' people amongst us:

Ultimately we concluded that none of the arguments we heard were sufficient to weaken society's prohibition of intentional killing, which is the cornerstone of law and social relationships. Individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions.

Other enquiries mentioned in your 1996 Report came to the same judgment. The New York State Task Force 1993:

No matter how carefully any guidelines are framed, assisted suicide will be practised through the prism of social inequality. The practices will pose the greatest risks to those who are poor, elderly, members of minority groups, or without access to good medical care.

Subsequent to the Federal debate of 1997, the Parliament of Tasmania held its own enquiry and its Committee came to the same conclusion:

The Committee found that the legalisation of voluntary euthanasia would pose a serious threat to the more vulnerable members of society and that the obligation of the state to protect all its members equally outweighs the individual's freedom to choose voluntary euthanasia.

¹ Mr Luke Gormally, "The British House of Lords - why it Rejected Euthanasia", address to the John Plunkett Centre, Sydney, November 10 1995.

That was a compelling argument in 1993, 1997, and 1998, and it has not changed. The Bill before your Committee might be titled in terms of rights, but it would bring in unintended injustice and subtle corruption of our relationships with the elderly and frail.

Reference 2.

The moment that, for many of us, crystallised this corruption in social relationships, this sense that laws purporting to support the “right to die” were really going to bring about an oppressive “duty to die”, was also referred to by the majority of Senators in your 1996 Report:

The potential for ‘guilt feelings’ for being a burden... may become such that they perceive a subtle duty on them to exercise the euthanasia option. The choice may well become a perceived duty. This is so especially when considered in the context of comments by those such as former Governor General, Hon Bill Hayden, that “There is a point when succeeding generations deserve to be disencumbered - to coin a clumsy word - of some unproductive burdens”.

As Governor General, Mr Hayden was speaking to the Royal Australian College of Physicians about his views on death and dying.² He identified himself as one of those "who, denied the choice of medically administered, painless, voluntary euthanasia, would wish to exercise the death option themselves."

But the main significance of this address by our Head of State was his suggestion that voluntary euthanasia is not merely a matter of choice but, more nobly, a positive obligation to society.

Mr Hayden reminded us of past cultures where the elderly would take poison or wander off into the forests when their usefulness to society was done. In the absence of forests, "the Inuits left their aged to float away on the ice". Elderly ancient Japanese "retreated to a mountaintop"; in fact the practice was for the elderly (defined as such by the loss of all teeth) to jump from the rim of a volcano for the greater good.

The question for Mr Hayden and other admirers of these practices is this: did the elderly Japanese jump or were they pushed? More subtly, did they indeed "choose" to jump but only because of an irresistible cultural push? How much autonomy were the abandoned Inuit's exercising? And is such a state of human relations admirable or degenerate?

Returning to the present, the Governor-General made the connection to our own elderly who, after "a full and satisfying lifetime" can become "unproductive burdens". He declared, as quoted by the Senators: "there is a point when the succeeding generations deserve to be disencumbered - to coin a clumsy word - of some unproductive burdens".

Within a day this newly articulated duty of the burdensome to do the right thing by society was given extra gravitas by another ex-Governor, the late Sir Mark Oliphant. Speaking on ABC Radio he praised Mr Hayden's views, and referred to an aged colleague in Canberra who "should be dead", who is a burden to his family but "likes being looked after". When

² The Hon Bill Hayden, Governor General, Address to the Royal Australian College of Physicians, 21/6/95, reported Courier Mail 26 June 1995.

the interviewer laughed and said "that's his right too", the blank response was that it was not, and that he was cluttering up the world when he shouldn't be.³

These are the sentiments, not of neo-Nazis snarling about "useless eaters", but of thoughtful citizens, respected Governors, shapers of social attitudes. They seriously propose that we develop a culture, like those described by Mr Hayden, where "unproductive burdens" will act for the greater good of society. These lonely and sick old people, already suffering low self-esteem and the sense of being a burden, would know when they had outstayed their welcome, and when to accept society's offer of assistance to die.

This is not an enlargement of "rights" and "choice" for these people. Given the psychological vulnerability of the average sick old person, the sense they already have of being "unproductive burdens", and the power of insensitive family or medical staff to reinforce this sense, such a decision will be made from a position of humiliation and weakness.

Professor Robert Manne gave a clear exposition of this central concern:⁴

Even the most elementary knowledge of human nature will tell us that while some families will treat older parents afflicted by terrible illness with love and respect, others will find the pain of their elderly parents merely ugly and their obligation of endless hospital visits over weeks or months distinctly tiresome. In such circumstances is it not at least possible that in the family discussions concerning the future, pressure will be applied which will suggest to someone who is terminally ill that no good can come from their purposeless clinging to life, that they have become a mere burden, and that they owe it to their suffering family to request an officially sanctioned death?

Will it not be the case even among those of the afflicted who are genuinely loved that some, in the depths of depression and fear, will imagine falsely that it is their death that their families most desire? And is it not precisely because of the recognition that, in a situation of legalised euthanasia, we cannot protect all of the terminally ill from insidious pressure of this kind that thus far no legislature in the world - other than that of the Northern Territory - has passed such a law?

Because the influx of this new coercive culture would be subtle and insidious, the prospect has less emotive impact on legislators than the vivid scene of terminal suffering. The urgent claims of mercy for the dying hold the attention better than the long-term concern of protecting the weak, the unwanted and the vulnerable from forms of oppression. But the gradual demoralisation of old people is a form of suffering. The social-suggesting of an "unproductive burden" towards suicide, when that person would never otherwise have chosen suicide, is a form of oppression, however indirect.

That, again, is the proposal before this Committee - whether to reopen the door to this new culture where 'unproductive burdens' know what is expected of them and do the right thing by society, or to keep the legislative door closed.

³Sir Mark Oliphant, ABC Radio A.M., 22/6/95.

⁴ Robert Manne, Quadrant editorial July 1995

Part 3: Medical considerations.

Medical opinions carry less authority than Parliamentary enquiries, but the overwhelming medical opposition to euthanasia is significant, and on similar grounds of preventing oppression of the weak, whose vulnerability doctors are intimately aware of.

So the AMA's Federal conference in 1995 voted 88 to 1 to uphold the World Medical Association statement condemning euthanasia (defined as "the act of deliberately ending the life of a patient").⁵

Past president of the AMA, The Hon Brendon Nelson, stated the obvious: "We will see people who feel pressure to die from a sense of guilt because they are a burden to family and friends, particularly given the depressive nature of a fatal illness."⁶

Professor Malcolm Fisher of the Royal North Shore Intensive Care Unit expressed similar misgivings: "Patients in Holland, and they are well documented, who do not actually want euthanasia are being talked or pressured into it by families, and I find that concept very difficult."⁷

An editorial in *Australian Doctor* was entitled "Risk of Forced Euthanasia", and discusses a woman with cancer whose husband could not cope with her illness:

Cathryn made me realise it would be such a short, easy step for subtle coercion to be possible if euthanasia were legal. Cathryn would feel she was a burden, of sound mind, and might ask for euthanasia - for John's sake - even though she didn't really wish it.⁸

An article on Physician-Assisted Suicide in the *American Journal of Psychiatry* predicts less than subtle coercion:

The elderly are often made to feel that their families would prefer that they were gone. Societal sanction for physician-assisted suicide for the terminally ill is likely to encourage family members so inclined to pressure the infirm and the elderly and to collude with uninformed or unscrupulous physicians to provide such deaths. Some advocates of changing social and medical policy toward suicide concede that such abuses are likely to occur but feel that this is a price we should be willing to pay.⁹

It is essential to realise the fact that this indisputable pressure on "vulnerable and disadvantaged people...to seek death", this lack of truly free consent to be killed, has been recognised internationally as a strong and sufficient argument against establishing medical killing of consenting patients.

⁵World Medical Association *Declaration on Euthanasia, Madrid, 1987.*

⁶Dr Brendon Nelson, *Australian Doctor*, 17 March 1995, p.7.

⁷Professor Malcolm Fisher, *Australian Medicine*, 5 September 1994, p.1.

⁸Dr Stephane Auchincloss, Medical Editor, *Australian Doctor*, 14 June 1996, p.19.

⁹Hendin H. and Klerman G. *Physician-Assisted Suicide: the Dangers of Legalisation*, *Am J Psychiatry* 150:1, January 1993, pp. 143 145.

Conclusion

Euthanasia brings increased 'rights' to some, but subtle oppression to others. Any law which fails to protect the most vulnerable is bad law. The Northern Territory ROTI Act should not be reactivated. Therefore the Bill before the Committee should be rejected.

Appendix

Clarification of 'euthanasia' and 'assisted suicide':

1. What euthanasia is and is not:

Euthanasia is intentional killing. If there is no intention to kill, then that is not euthanasia.

- The Qld State Chairman of TRUST, Dennis Galligan QC, emphasised this point: "The crucial distinction is the intention with which treatment is given; the intent to cause death is euthanasia; the intent to relieve pain/suffering is not euthanasia."
- There is *no intention to kill* when a doctor gives adequate morphine to relieve pain, even if it appears to hasten death, and therefore that is not euthanasia.
- There is *no intention to kill* when a dying person is taken off artificial life support, there is merely an acceptance of inevitable dying, and the provision of all supportive care while the person dies.
- The essential test is this: *what would you do if the person kept living after one of the above acts?* If the person lives on after life-support is ended, then you would sit with the person and give all care, for however long they had yet to live. That is not euthanasia. If the person lives on, free from pain, after adequate morphine, then life goes on as usual until pain returns and a further dose is given. There is no intention to kill, only to relieve pain. If, however, the person lives after a lethal injection has been given, you would give another and another until the person was dead - because that is the intention of the act of euthanasia.

2. What physician-assisted-suicide is and is not:

This differs from euthanasia in that the doctor does not kill the patient, but helps the patient kill himself. It has nothing to do with the patient refusing medical treatment: if a patient refuses any medical assistance for any reason, even knowing they will die as a result, that is entirely within their rights. Consider the following:

World Medical Association Statement on Physician-Assisted Suicide (Spain, 1992):

Physician-assisted suicide, like euthanasia, is unethical and must be condemned by the medical profession. Where the assistance of the physician is intentionally and deliberately directed at enabling an individual to end his or her own life, the physician acts unethically. However the right to decline medical treatment is a basic right of the patient and the physician does not act unethically even if respecting such a wish results in the death of the patient.

This WMA statement was supported by a vote of the Australian Medical Association Council in 1995, 88 votes for, 1 against.