

**EUTHANASIA AND PALLIATIVE CARE: PHILOSOPHICAL AND ETHICAL CONSIDERATIONS**

**PRESENTED TO PALLIATIVE CARE COUNCIL (INC)**

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I am a former military officer who served in a combat arm. After nearly 30 years including service in operational areas, I retired to take up a senior teaching position at a boy's College in Canberra. For a further 20 years I taught Ancient and Modern History and Introduction to Philosophy and Ethics. Recently I joined the ACT Palliative Care Visitors' program. Obviously I am neither an academic ethicist nor a palliative care clinician, however my professional life experience has exposed me to pain, suffering and death and their consequences on others and me. I am a practicing Christian (Catholic) and my own process of ethical awareness has been deeply influenced by my faith. In the course of my studies over many years I have also developed a considerable interest in the extent to which secular humanism and the tenets of the faith of those who profess Judaism, Orthodoxy, Islam, Buddhism, Hinduism and the various branches of the Protestant Churches has contributed to the ethical formation of people.

**SUMMARY**



The support by some (but not all) pro-euthanasia advocates may emerge from genuine feelings of compassion for those confronted by pain, isolation and loss of dignity. But the means by which a particular form of release from these conditions is being sought is clearly against present laws in most jurisdictions in the world. The matter is made more difficult because there is considerable confusion surrounding this term - euthanasia. Different sources and the context of its use in writing and debates

vary quite widely depending on the point of view the author wishes to express. I shall argue, in this paper that the term, Passive Euthanasia is frequently employed for the purpose of attracting support by pro-euthanasia advocates whose agenda is to legalize the killing of, in some circumstances, defective infants, unconscious and the non-competent elderly and the new born. Voluntary suicide or provision of medically assisted suicide is also a plank in the proposed policy of these advocates

This paper attempts to more accurately define euthanasia and to separate the term from the efforts of various self interest groups to redefine it as an ethical response to so-called "end of life choices."

I consider that for palliative care clinical and non-clinical professionals or volunteers, the case for euthanasia fails utterly. It does so because euthanasia:

- Rests on premises that have no respect for life.
- Rests on premises that philosophically are basically utilitarian.
- Is frequently presented in deliberately or unwittingly misleading terms.
- Has no legal authority anywhere with the exception of the Netherlands, Belgium and Oregon State in the USA, although “End of Life legislation” is pending in a number of other jurisdictions. Pro-euthanasia legislation, where it exists, is manifestly unsafe.
- Has been rejected in the United Kingdom, Canada, France, Israel: in the USA - the State of New Hampshire: the European Court of Human Rights, and, in Australia – South Australia and Western Australia.
- Is contrary to established medical ethical standards and contrary to best medical practices.
- Garnishes support from people who, for whatever reason, are not in possession of all the relevant facts.
- Is inconsistent with the universally accepted aims of palliative care as stated in the World Health Organization and affirmed by Palliative Care Australia.
- Is inconsistent with the Little Company of Mary Health Care (LCMHC) Mission Statement.

I therefore reject the notion, that palliative care has any legitimate part to play in an “end of life choice” that involves the deliberate death of a patient.

On the other hand I do believe that it is essential that we acquaint ourselves with the reality of euthanasia, the examples of failure to regulate the implementation of euthanasia legislation where it has been introduced and not allow ourselves to be seduced by the subjective arguments favoured by pro-euthanasia advocates. Such undertakings can be made in a true spirit of compassion.

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## INTRODUCTION

By the end of the 19<sup>th</sup> Century it became apparent that the moral heritage and ethical imperatives that underpinned the formation of European civilization were changing. In the first half of the 20<sup>th</sup> century many Western countries laws were being passed which required compulsory sterilization of people with developmental disabilities. In England, Home Secretary Winston Churchill introduced legislation to “stop society being overrun by idiots.”<sup>1</sup> In Germany there was a rise of the eugenics movement and the establishment of euthanasia facilities that preceded the Nazi policies against the Jews. An alternative value system, better known to us as Consequentialism and Utilitarianism,<sup>2</sup> was increasingly being applied to a whole range of societal activities. This trend continues today.

It initially came as some surprise to me that the subject of euthanasia has arisen in the context of those engaged in what is clearly both a vocational and professional pursuit - palliative care. However, I am very much aware of the growing interest in the role of euthanasia in Western or developed world communities in the past decade. Previously, as a topic of public discussion, it had little currency except in learned and philosophic circles, or in the context of its discredited application based on racial grounds in Nazi Germany. My surprise has been that some people associated with palliative care should regard euthanasia as a genuine “End of Life Choice” that may in some way be connected with an accepted definition of Palliative Care. As with any staff member or volunteer worker at Clare Holland House, I am aware of the Mission Statement displayed in the reception area. (See Definition No 1.)

## THE STATE OF AFFAIRS TODAY

To deliver some sort of satisfactory philosophical analysis of the world as we enter the 21<sup>st</sup> century is beyond the scope of this paper. However, the issue of euthanasia cannot, and should not be ignored. I introduced this paper by stating that I was puzzled as to why the palliative care community needed to consider it. But there are certainly some compelling reasons why we should.

- There is a pressing need for us to reinvigorate an *ethical approach* to resolve moral dilemmas and complexities.
- Medical practitioners, associated clinicians and volunteers need to ensure that their current knowledge and training is appropriate to the task of delivering the highest achievable level of palliative service.
- Every effort should be made by the relevant bodies to secure government funding to support levels of staffing and equipment as to enable Hospices and Aged Care facilities to deliver the appropriate level of care.<sup>3</sup>
- We need to be better prepared to see through the seductiveness of political posturing where self appointed “champions of compassion” can misdirect our own natural instincts to relieve pain, suffering and feelings of worthlessness in those we care for.
- We need to develop greater confidence in and knowledge of the medical practice of pain relief even if we are not actively involved in its administration.

- We need to develop the confidence to refute some of the misinformation and unethical practices engaged in and promoted by active pro-euthanasia groups.
- We need to recognize that palliative care encompasses the full range of best medical practice. In doing so we should note that Palliative Care Australia (PCA) recognizes the World Health Organization definition of palliative care.<sup>4</sup>

## AIM

The aim of this paper is to show that, despite the deeply held feelings of some if not many pro-euthanasia supporters, euthanasia in whatever guise fails to deliver anything other than a calculated and premeditated death.

This paper will also show that this stark reality can be deliberately or unwittingly obscured by the provision of significant misinformation, an absence of accurate information and can and has given rise to an opportunity for exploitation of society's most vulnerable people and those who love them. "Throughout history, civilizations have been judged on the basis of the care we provide for the weakest members of our society."<sup>5</sup> The civilization to which we belong will not be spared judgement.

## DEFINITIONS

For the purpose of this paper, the following statements and definitions apply:

- **No 1: Calvary Hospital Mission Statement**

"[Clare Holland Hospice] bring[s] the healing ministry of Jesus to those who are sick, dying and in need through 'being for others.'"<sup>6</sup>

- \* **No 2: Palliative Care World Health Organization (WHO)**

WHO defines palliative care as an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.<sup>7</sup>

- **No 3: Palliative Care Australia (PCA)**

PCA defines palliative care as . . . "specialist care provided for all people living with, and dying from an eventually fatal condition and for whom the primary goal is quality of life."<sup>8</sup> PCA also states: "that palliative care practice does not include deliberate ending of life (euthanasia), even if this is requested by the patient."<sup>9</sup> But it should also be noted that PCA also has a clear policy of studied neutrality in the matter of euthanasia itself.<sup>10</sup>

\* **No 4: Euthanasia. (Noun)**

In recent times the word Euthanasia (from the Greek = “good death”) has come to be generally defined as a “gentle death brought about to alleviate a painful, unendurable and incurable condition.”<sup>11</sup>

\* **No 5: Euthanize (Verb)**

To subject to euthanasia, [hence] “dog was euthanized at owner’s request.”<sup>12</sup> Although it must be noted that dictionaries in more general use do not include “Euthanize v.t.” at all despite the growing practice to use euthanize to describe the action that claims to bring about a gentle and easy death.

\* **No 6: Active (also called Direct) Euthanasia**

Within this definition, it is the general practice today to define the variants as applied to human beings as follows:

**No 6A: Voluntary Euthanasia.**

This refers to patients who are mentally competent and who asked to be killed in order to relieve distress, either physical or emotional which they declare to be intolerable.<sup>13</sup> In response, someone would kill them, with intent.<sup>14</sup>

**No 6B: Non-Voluntary Euthanasia.**

This refers to killing patients who cannot give consent for any reason, and includes: those people who suffer from senility, cognitive impairment or development disabilities, or new born infants with a disability, in order to end their suffering.<sup>15</sup> This practice is usually to distinguish involuntary euthanasia that means putting some to death against their wishes in order to end suffering.

**No 6C: Medically Assisted Suicide**

Prescription by request by a terminally ill patient to a medical practitioner for a lethal quantity of a drug or by the provision of some device, the purpose of which is to facilitate the patient to take his or her life. This definition is an example of Definition 6A.

\* **No 7: Passive Euthanasia**<sup>16</sup>

Passive Euthanasia means deliberately bringing about death in order to end suffering by withdrawing care that is *not* overly burdensome. It is to be distinguished from withholding life-prolonging treatment that *is* overly burdensome.

\* **No 9: Consequentialism and Utilitarianism**<sup>17</sup>

Consequentialism includes a group of philosophies with differing emphases but with the common premise that the morality of an action is determined by evaluating its outcome. It includes utilitarianism that means choosing that act

which is considered to produce the highest average or total happiness or preference satisfaction. Other forms of consequentialism include hedonism, egoism and some forms of justice theory that seek to modify utilitarianism by protecting the highest possible equal liberty and perusing that system which will do the best by the worst off in society. Most forms of consequentialism support voluntary and non-voluntary euthanasia.<sup>18</sup>

\* **No 11: Ethics**

The method of study that determines the types of activity that are good, right and to be done or bad, wrong and not to be done in order that one may live well.<sup>19</sup> Aristotle<sup>20</sup> (384-322 BC) was an early exponent of this concept. In recent years it has become an increasingly popular, although deeply flawed and subjective process, to assert that ethics of autonomy, which is the claim that individuals are free to determine what, is “good” and “bad” according their own needs. (See Definition 12 below.) The obvious corollary to this is that there are no absolute values.

\* **No 12: Relativism<sup>21</sup>**

Relativism is the position that all points of view are equally valid and the individual determines what is true and relevant for them. Relativism theorizes that truth is different for different people, not simply that different people *believe* different things to be true. While there are relativists in science and mathematics, *ethical* relativism is the most common variety of relativism. Almost everyone has heard a relativist slogan:

- “What is right for you may not be what is right for me.”
- “What is right for my culture will not necessarily be what is right for your culture.”
- “No moral principles are true for all people at all times and in all places.”

## THE CONTEXT

### The Political Front: Overseas

The Euthanasia Bill currently in place in the Belgium and the Netherlands is not without legal flaws. The UK House of Lords select committee examining the proposed UK Bill was informed that some elderly citizens of the Netherlands tend to seek medical attention *outside* their country for fear that euthanasia may be enacted on them without their permission being given.<sup>22</sup> The State of Oregon in the USA and Switzerland are another two jurisdiction in which medically assisted suicide (euthanasia) has been successfully enacted, but has resulted in unexpected and dire consequences as a result of legal weaknesses in regulation.<sup>23</sup>

Transcripts of the House of Lords' debates<sup>24</sup> reveal other areas of concern of both Dutch and UK doctors and provided other telling observations on the danger of introducing a Euthanasia Bill in the UK. A selection of these comments include:

- Reference to a Dutch Medical Journal that, at Groningen Hospital in 2005, doctors had killed twenty-two babies born with *spina bifida*.
- Only 50-60% of cases of euthanasia in the Netherlands are reported to the proper authorities.
- Non-voluntary euthanasia is widely practiced in the Netherlands and the grounds for it have gradually been liberalized such that it is now permissible for people who are merely tired of life to seek voluntary euthanasia.
- The Dutch legislation does not provide an effective regulatory framework for assisted suicide and euthanasia.<sup>25</sup>
- Dr Nigel Sykes, the Medical Director of St Christopher's Hospice in London noted that there was sympathy for euthanasia among the general public. "However" he said, "patients themselves do not want euthanasia."<sup>26</sup>
- Only 3.5% of patients dying of cancer [in UK] wanted euthanasia.<sup>27</sup>

**Rommelink Report.**<sup>28</sup> In 1990 the Dutch Government appointed Dr P. van der Maas of the Erasmus University to enquire into the practice and inaction by a doctor that may lead to the end of a patient's life at the patient's explicit and serious request or otherwise.<sup>29</sup> Despite amendments to the legislation addressing "End of Life Medical Practices," at least two subsequent cases (Dr Chabot and Dr Henk Prins) exposed the inadequacy of the law.<sup>30</sup>

### Political Front: Australia

In the past decade, the euthanasia issue has surfaced from time to time. More recently serious attempts have been made to get pro-euthanasia legislation onto the table. Mr Michael Moore (Ind.) put up his euthanasia bill three times in the Australian Capital Territory Assembly. Each time it was defeated. In a total of approximately 200 written submissions from the public, 91% of respondents opposed the legislation.<sup>31</sup>

Pro-euthanasia legislation was passed in the Northern Territory in 1996.<sup>32</sup> The Commonwealth Government then overturned it under the provision of an Act that gave the Parliament authority to exercise such power over the Territories<sup>33</sup>. However, this was not before Dr Nitschke<sup>34</sup> responded to an alleged expression of need on the part of a number of people and facilitated their death. Since then the Greens Party – the party that has shown the most substantial support for euthanasia has been taking the opportunities presented in the current context of a hung parliament. Senator Bob Brown (Greens) has a proposed bill<sup>35</sup> on the table designed to grant "political autonomy" to the Territories, which opens the door



for both the ACT and the Northern Territory to resurrect their own pro-euthanasia bills if they wish. Prime Minister Julia Gillard will handle this remains to be seen.

## THE ANALYSIS

### Manipulating words and meaning to suite particular agendas

Words, words, I'm so sick of words . . .<sup>36</sup> A matter demanding our attention involves the popular pastime of redefining words to suit a particular agenda. This process either expands the original meaning far beyond the accepted definition or totally redefines it. I do not need to give many examples outside the scope of this paper but the use of such words in the public forum as "gay," "equality," "rights," "journalistic code of conduct" and "marriage" readily come to mind. I am conscious of an observation made by Dr John Rosenberg<sup>37</sup> in the course of discussions with him on 4 August 2011. He pointed out, quite correctly, that English is a living language. It will continue to *refine* and *redefine* words as well as discarding the meanings of some as common usage changes. Great care is needed, however, to discern where a line should be drawn between the expression of a motive by an outspoken group and a satisfactory agreement on the extent to which usage is "common."

Nevertheless, the euthanasia debate is bedevilled by examples of the use of language, rather than the argument the words are meant to convey in influencing how the statement is received. In a report of the London Institute of Medical Ethics Working Party on the Ethics of Prolonging Life and Assisting Death<sup>38</sup> contained the following examples:

- \* The rejection of the word "killing" on the grounds that it does not reflect the "gentle act of merciful clinical care."<sup>39</sup>
- The report refers to "assisted suicide" and "homicide on request" but cautions against their use "lest their legal implications confuse the ethical issues."<sup>40</sup>
- The reference to "hasten[ing] death by administration of narcotic drugs" may be the practice but the use of the word "hastening" seems to avoid the obvious ethical issue.<sup>41</sup>

So I turn now to the newsletters of *Dying with Dignity NSW (DWD)* whose mission statement is to:

. . . lobby for legitimate change that will enable terminally ill individuals who are suffering and have no prospect of recovery to be able to access medical assistance to help them die in accordance with their wishes.<sup>42</sup>

A review of the organization's newsletters,<sup>43</sup> and comments made in public debate<sup>44</sup> shows that its mission is far more comprehensive than this. It unequivocally promotes the following:

- That DWD (NSW) is a legitimate voice of a contemporary and compassionate society. But its support of euthanasia has a far wider application than that stated above.<sup>45</sup>



- \* By implication, and in some cases by explicit challenge, it claims that those who oppose this assertion lack compassion.
- \* That the majority (75%) of Australians support euthanasia (including 65% of Christians, 62% other Religions and 91% of no religion.)<sup>46</sup>
- \* The philosophy of Peter Singer,<sup>47</sup> and the activism of Dr. Nitschke.
- \* Apportioning the blame for the failure of government to enact pro-euthanasia legislation to the interference and influence of “the Churches.”<sup>48</sup> More recently he has attacked what he regards as the intransigence of the various Medical Associations.<sup>49</sup>

### The Scandal of Slippery Subjective Sampling

For those familiar with the activities of Sir Humphrey Appleby in the TV comedy *Yes Minister* and *Yes Prime Minister* the advantages of subjective sampling was the topic of one of Sir Humphrey’s tutorials with Bernard.<sup>50</sup> Too many of the samples conducted in the past decade have been examples of this technique. Respondents are asked whether they favour euthanasia or unendurable pain? Predictably the majority would wish to reject the scenario of unendurable pain and choose the only alternative offered. The first example of this sort of public polling that I am aware of was in Victoria in May 1986. Morgan pollsters asked: “Should the terminally ill have the right to choose to die?” 86% answered ‘yes.’ Pollard<sup>51</sup> noted that it was not clear from that response whether respondents interpreted the question as a reference to the right to choose that their illness be allowed to run its course without further interference. Two years later another survey<sup>52</sup> asked a similar question made even more ambiguous by the use of euphemisms. DWD’s recent sample of 1,294 Australians responded the same way. (See above) Because the response from NSW was stated as being at “an even higher level of support [for euthanasia],”<sup>53</sup> the assertion was that “with over 80% of Australians’ supporting the legislation for medically assisted dying, support for voluntary euthanasia should be seen as ‘mainstream.’”<sup>54</sup> However, it is hoped that in the future, rational people will be pressing for a demand of *a clear definition of euthanasia* and the strongly dispute the implication of the pro-euthanasia supporters that euthanasia is the *only* compassionate option. Any palliative nurse or doctor would be horrified at the implication that there is no other option! So would *Palliative Care Australia* and *Calvary Palliative Care Services*. So would the leaders of all the main body religions<sup>55</sup> and many whose ethical life is informed by principles of secular humanism. It is entirely appropriate to quote the paraphrasing by Dr. Margaret Summerville of an Australian Aboriginal elder speaking to White Australians on behalf of probably the most fragile social component of our society.

we need to find a ‘new dreaming’ –especially one that can hold us when we are facing death. We must be able to experience belonging to something bigger than ourselves; a sense of hope – a connection with the future; a sense that we are loved and can love in return. All these feelings are possible for dying people – but probably only if those who care for and relate to them can also give and accept the experiences that generate them.

Buddhism also incorporates strong moral imperatives that guide its members along the “path of righteousness.”<sup>57</sup> A spokesman for the Hindu community affirmed its opposition to direct killing at a public presentation in the National Gallery, Canberra, in 2010.

### **Making words mean what one wants them to mean**

**“Compassion.”** The word “compassion” invokes one of the most powerful expressions of what it is to be human. Sullivan and Heng write that “[h]uman beings are inherently relational through knowing and loving others and being dependant on one another.”<sup>58</sup> Later the authors observe: “[h]uman beings are naturally inclined to preserve their lives, to contribute to the common good, and to protect the innocent.”<sup>59</sup> The truly compassionate person responds to a fellow human being in physical or mental pain with the desire to heal and sooth. The compassionate person seeks to bring hope to the hopeless, shelter to the homeless and security to the insecure. The compassionate persons shares the hurt where possible, brings companionship to the abandoned and peace to the frightened.

It seems to be a perverse form of “compassion” by removing the life along with the suffering. The philosophical dilemma is whether the act of extinguishing the life can be justified because it removes the suffering. When one thinks of the relatively unskilled carers who worked so diligently in medieval hospices, can we regard them as less compassionate than advocates today with the means and inclination to practice “mercy killing”?

The basic ethical premise of the intrinsic value of human life has long been regarded as being in the natural order of things. It is the keystone of the Christian, Islamic, Judaist, Buddhist and Hindu philosophies. Of course it is *not* critical in the utilitarian schools of philosophy. With utilitarianism it is expressed in a number of ways. Dr Nitschke expressed *his* views as:

Many people I meet and argue with believe that human life is sacred. I do not. I believe the so-called “sacredness of human life” has been responsible for most of the wars, genocidal (sic) crimes and global environmental and ecological disasters that we as species have experienced.<sup>60</sup>

There is still a great deal of worldwide support for the United Nations Charter on Human Rights,<sup>61</sup> despite examples of indifference on the part of some nations. In theory, the majority of people therefore support the statement on the inalienable and inviolable rights of humans to life. Clearly, the right to life cannot be given up as an expression of compassion in some cases without the right to life of others being put at risk.

In August 2010 I attended a public meeting in Canberra that was recorded by ABC radio. A number of speakers were offered the opportunity to explain their views on euthanasia. Despite some effort by the Moderator (ABC Radio Paul Barclay) Dr Nitschke quickly dominated the discussion, pouring scorn on a palliative care doctor and an academic, then expounded on his own credentials for compassion and honesty. In my view he failed utterly. When I asked him how familiar he was with practices in Hospices and in the care and treatment of terminally ill by clinicians and devoted visitors in palliative care organizations, his response, somewhat disingenuously, was: “you haven’t seen what I see every day.” The microphone was taken away from me before I could say how thankful I was

that I had not witnessed *his* “acts of compassion.” Nitschke also summarily dismissed the view of another speaker on the platform that tried to make the clear distinction between the *motives* for Active Euthanasia and the so-called Passive Euthanasia.

**“Passive.”** The frequent use of the word “passive” in the euthanasia debate certainly softens the image created by the use of “active” where it is impossible to define it as anything other than direct killing. It is entirely possible that this softening strategy is a deliberate ploy of gaining credibility for what advocates claim are euthanasia practices that are ethical and prudent. But by inviting people to support such practices they seek to gain recognition of an invalid definition of euthanasia. Of course, if these practices were used for the purpose of “deliberately inducing death by the withholding of treatment necessary to sustain life” then such practice would be the moral equivalent of active euthanasia by omission rather than by commission. This would also apply whether the treatment was simple, such as the provision of food and hydration by normal routes or sophisticated as in the use of a respirator. Accordingly, I believe that DWD and like ilk are attempting to appropriate sound practice and re-badge it as a more promotable form of killing.

**“Best Medical Practices.”** The following practices form part of what can validly be described as “end of life choices.” They are medically and ethically appropriate. Such choices can be a recorded legally and are binding upon families (those who have power of attorney) and medical staff. Such practices include:

- *Discontinuing* treatment that is overly burdensome or is of no benefit (futile) to benefit the patient. This decision is at the discretion of the doctor or at the request of the patient or both but where there is no intention to take life.
- Deciding *not* to commence treatment that is overly burdensome or is no benefit (futile) to the patient.
- Using various methods to control severe pain even though this may shorten life.<sup>62</sup> The prospect or danger of “shortening life” is probably no longer creditable today. Good palliative care can control pain and assist a patient to live more fully with the dying process without it hastening death. Relieving pain is more likely to lengthen life than shorten it.
- Not reviving, or enacting extraordinary medical processes, when the patient is at the point of death.

**“Dignity.”** Dying with Dignity (DWD) promotes the strong inference that it is the provider of “dignity” for those dying in unendurable and un-relievable pain and suffering and seek a “dignified” release. It is true that we frequently hear the expression “death with dignity.” It is somewhat frustrating to try to determine the numbers of those advocating it and those actively seeking it. Clearly it means different things to different people. For some it may mean comfort, cleanliness, absence of pain, and connection with family. For others it may be for the relief of present suffering or a euphemism for euthanasia request. The experience of Dr Pollard was displayed in this area when he delivered a paper to a seminar in Canberra

in 1992 entitled “Palliative Care: Is it the Answer?”<sup>63</sup> In his observations on this matter of death with dignity, he said:

All sick evoke our compassion and draw forth our caring response. The dying are still part of the living community, and they merit the dignity due to every living person. We truly respect and support their dignity when we show them that we value them, inherently and for their gifts, relieving their suffering, seek and respect their wishes and let them know that we do these things in recognition of our human interdependence. In such actions, we also express and validate our own dignity while we can, knowing that our turn to receive may come soon enough.<sup>64</sup>

Daniel Sulmasy<sup>65</sup> identifies three senses of human dignity in Western philosophy. “*Intrinsic human dignity* is the value that human beings have simply by virtue of the fact that they are human beings . . .” “*attributed human dignity* is the value that human beings confer upon others by choice and convention [and] “*inflorescent human dignity*” is the value of human excellence or virtue.” To assign human worth only on the basis of its productivity, its degree of economic burden on the state, or its inconvenience to society may all have some merit for those who advocate utilitarian philosophies such as Singer and Nitschke, but it would be difficult to recognize a society thus ordered as being one that is distinguished by compassion or dignity.

**“Suffering.”** It is a common although not entirely legitimate practice to assume that pain and suffering are synonymous. While they may frequently occur together, they are separate experiences. Doctors certainly have training in the recognition of pain, the underlying causes and the remedies that are available. As far as I can judge from discussions with friends and colleagues who practice medicine, the matter of suffering receives less attention in their long and exacting studies. Suffering is, perhaps, better described, not in the same terms of pain but as an experience of the mind. It is fuelled by disappointment, anger and resentment, loneliness, a wish not to be a further burden on society or family, to name but a few. The condition can be terrible but can rarely be addressed by drugs. It can certainly be totally relieved by deliberately killing the person but is this genuinely a humane response? The challenge to answer this question lies heavily on the shoulders of the medical profession, their trainers and mentors and those of us responsible for the care of family, friends and members of our society.

## LIFE AND DEATH ISSUES

### The Difficult Cases

One cannot avoid the presence of “difficult cases”. Nor would I wish to do so. No one would claim that making decisions that relate to impending death are simple to resolve.

As a guide to relieving pain, the World Health Organisation provides its WHO ladder for cancer pain, and states “the WHO ladder for cancer pain is a relatively inexpensive yet effective method for relieving cancer pain in about 90% of patients.”<sup>66</sup>

DWD sources will provide us with the accounts of many difficult cases although in the general scheme of things they are well publicised but unrepresentative of the number of people dying. We are rarely made aware of all the circumstances. We meet people all the time who have had various experiences most of which will be complicated by personal

connections which one cannot expect have been considered objectively. Rarely too do we have the opportunity to ask whether appropriate medical advice was provided or whether proper palliative care treatment was available and put into practice. Often unacceptable standards of care are in place because it is not known that better standards, including knowledge of the WHO ladder data, can and should be expected and are available. If the appropriate standards are *not* sufficiently available, the reasons for the situation should be investigated and urgent action taken to address the failure to deliver. It is certainly unacceptable to conclude that it cannot be afforded or that euthanasia is a suitable alternative. The issue can also be complicated by the acceptance of any one of a number of primary statements that are demonstratively untrue.

I quote the following examples cited by Pollard as being often stated, usually by non-clinical people.<sup>67</sup> When I put these examples to a number of doctors, some of whom work in palliative care, and some palliative care nurses the responses were uniformly as follows:

- ***“All cancer is associated with pain”.*** Not so. About one third of cancer patients experience no pain or moderate pain.<sup>68</sup>
- ***“The pain of cancer always get worse as the illness progresses.”*** Not so. It is quite common for such pain not to progress at all or to do so only slowly.
- ***“Cancer pain eventually becomes severe that it cannot be relieved.”*** This should not be true except in most rare cases – “un-relievable pain” is only what somebody has not been able to relieve. Expert care will abolish or relieve virtually all cancer pain. Global clinical data indicates that about 90% have controllable pain.<sup>69</sup>
- ***“If medication is started too early it will lose its effectiveness.”*** This is one of the really damaging myths that prevent patients from taking and professionals from prescribing adequate medication at the right time.
- ***“If painkillers are taken regularly, the patient may become an addict”.*** This is a common reason for poor medication. In the circumstances the suggestion verges on the absurd.
- ***“Morphine is only administered when the end is near.”*** Morphine has been in common use for some time now, started when the doctor thinks the severity of the pain requires it; its use is not typically (or always) to do with the stage of the illness.<sup>70</sup>
- ***“Regular use of painkillers will shorten life.”*** As referred to previously it is not common for painkillers to have any effect at all on the length of life. They may sometimes shorten it but just as often will extend it. In any event the *correct* use of the medication is simply *not* euthanasia.

### The Role of Medical Practitioners

It appears that medical graduates are no longer obliged to take the Hippocratic oath.<sup>71</sup> It is reasonable, however, to presume that both the medical profession and its patients expect a commitment to the belief that the doctor still has the duty to do what is in the best interest of the patient. The responsibility for the provision and regulation of medical care today lies increasingly with the state. The state exercises its authority through

legislation that is expected to benefit the whole of society. If, however, the utilitarian benefit to society takes precedence over the benefits and rights inherent in each patient, then that traditional, unique and intimate relationship between doctor and patient begins to be eroded. No better example could be cited than the likely role of the medical professionals if euthanasia legislation is introduced. The ethics of medical practice have always been at the heart of the patient/doctor relationship in which one entrusts to the other his or her life and health. If the state requires the medical profession to become an agent of state sanctioned death, it will be to ignore or dismiss the example in Belgium and the Netherlands and to expose our society to an acceptance of a utilitarian definition of "compassion." It could also invite recognition of a new and radical medical paradigm – those that cannot be cured can be killed.

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#### ENDNOTES

<sup>1</sup> In a letter to Prime Minister Asquith, the Home Secretary wrote:

"The unnatural and increasingly rapid growth of the feeble-minded middle classes, coupled with a steady restriction among all the thrifty, energetic and superior stocks constitute a race danger which it is impossible to exaggerate. I feel that the sources from which the stream of madness is fed should be cut off and sealed up before another year has passed."

Cited in Dr. Nicholas Tonti-Philippini "The West started Culling the Feeble before the Nazis," *The Record on Line*, 19 January 2011.

[http://www.therecord.com.au/site/index.php?option=com\\_content&task=view&id=2259&Itemid=27](http://www.therecord.com.au/site/index.php?option=com_content&task=view&id=2259&Itemid=27)

<sup>2</sup> See Definition No 9 and Smart J.J. and Williams B. *Utilitarianism: For and Against*, Cambridge University Press, 1973.

<sup>3</sup> I am unable to give an authoritative assessment of the whole of palliative services throughout every State and Territory in Australia, but my observations of the operation of the Clare Holland House Hospice in Canberra, ACT, would seem to show that it is very well served by the generosity of many private and corporate donors and the devotion of many dedicated volunteers.

<sup>4</sup> See full expression of what this includes in PCA, *Voluntary Euthanasia and Physician Assisted Suicide*, 2008, page 2 and our Definition No 3.

<sup>5</sup> Professor Greg Craven, Vice Chancellor Australian Catholic University (ACU), speaking at the opening of the Calvary Centre for Palliative Care Research, jointly sponsored by Calvary Health Care (ACT)/ACU. Professor Craven (BA, LLB (Hons) LLM (Melb) is an expert in public law. He has held senior academic and executive appointments at Curtin University, the John Curtin Institute of Public Policy, the University of Notre Dame, Australia, and University of Melbourne. He was also Crown Counsel to the Victorian Government from 1992-95.

<sup>6</sup> Of course, such a statement does not demand that all members of staff have to be confessional Christians any more than the patients. But regardless of denominational associations it is in my experience and observation that those who serve in palliative care do so with the knowledge of or instinct for the biblical command “love one another as I have loved you.” (Jn 13:34)

<sup>7</sup> <http://www.carenokilling.org.uk/?show=182>

<sup>8</sup> Palliative Care Australia *Voluntary Euthanasia and Physician Assisted Suicide: Position Statement*, 2008. I understand that PCA is updating this document, but I have no indication that this definition is likely to be altered significantly nor is its unequivocal position on euthanasia as expressed in the statement in **Background** - “Euthanasia is *not* part of palliative care practice.” (Emphasis added). See also:

[http://www.palliativecare.org.au/Portals/46/Palliative\\_Care\\_Consensus\\_Statement\\_final.pdf](http://www.palliativecare.org.au/Portals/46/Palliative_Care_Consensus_Statement_final.pdf)

<sup>9</sup> PCA Media Release, 1 February 2007. <http://www.palliativecare.org.au/Portals/46/Media/euthanasia%20media%20release.pdf>

<sup>10</sup> This disappointing position was affirmed at a recent Palliative Care “Retreat” for ACT Palliative Care Society volunteers. Although the CEO of PCA said that she was aware of the legal consequences of euthanasia legislation in Belgium, the Netherlands and Oregon State (USA), she did not appear to regard the impact on the medical profession in Australia of the proposed pro-euthanasia legislation to be a subject of interest by the audience. At a previous social gathering of volunteers, interest had been expressed in the subject. It was my understanding the “retreat” would, in part, address this expression of interest. Discrete

comments made to me by some attendees during the morning tea break led me to believe that this interest remained in force. In one example I was asked if I was against all euthanasia including passive euthanasia. The questioner was quite shocked when I said I was opposed to any act whose purpose was to deliberately cause the death of the subject. I also said that there was no such thing as passive euthanasia. The enquirer was clearly a good and compassionate person but, sadly, ignorant of how I could come to the point of view I held. Another person asked me how my opposition to euthanasia could overlook the genuine feelings of those who supported it? This question is addressed in this paper at some length. I was also disturbed by the fact that whilst the aim of the retreat was, amongst other stated aims, for the purpose of addressing the expressed interest of some of the volunteers about the whole question of euthanasia and “end of life choices,” the euthanasia issue was dodged at all sessions I attended. One speaker, despite avoiding comment during an introductory presentation on the grounds that it could be better addressed during question time, responded to a later question in only very general terms. I continue to be apprehensive that we are ignoring the same problems currently being experienced elsewhere where legislation has been enacted because of the preferred policy of studied neutrality by a significant professional body.

<sup>11</sup> A German scientist originally proposed the idea in 1895. In 1920 Karl Binding co-authored a book called *The Right to Die*. The philosophical justification in both publications was strictly utilitarian. (See Definition No 9.)

<sup>12</sup> *Miriam-Webster’s Medical Dictionary*, 2007. Dictionary.com. Online Etymology Dictionary. Douglas Harper, Historian. <http://dictionary.reference.com/browse/euthanize> (accessed: July 29, 2011).

<sup>13</sup> Notwithstanding this description of the conditions required for justification, in the Netherlands the word “intolerable” is being replaced by the term “those who are tired of life.”

<sup>14</sup> As the law currently stands in Australia and elsewhere in most of the world, this practice would be legally regarded as “homicide by request.”

<sup>15</sup> As matters stand at the moment these actions would be examples of homicide by the agreement of parties other than the subject

<sup>16</sup> There is considerable confusion surrounding this term. Different sources and the context of its use in writing and debates vary quite widely depending on the point of view the



author wishes to express. I shall argue, in this paper, why the concept of Passive Euthanasia is falsely named and that many of the practices alleged to be part of the *passive* treatment are, in fact, simply profoundly good ethical and medical practices. The determining factor will always be that of motive. If the purpose of the action is to bring about death, then that action is deliberate killing. In the context of an end of life decision, someone is advocating *active euthanasia*.

<sup>17</sup> I am grateful to the advice of Professor Nicholas Tonti-Philippini in providing the precision of this definition.

<sup>18</sup> Dr Brian Pollard, MB., BS., DA., FRA RACS., *Euthanasia; Should we Kill the Dying?* Little Hills Press Pty. Ltd, UK, 1988, page 26. Dr Pollard is a medical specialist in anesthesia and palliative care, well known and highly respected in palliative care circles. For many years he was prominent in educating clinicians and non-clinical members of the public in the extraordinary advances in palliative care medicine. Since the publication of the reference above, the advance in this branch of medical science has continued to grow. For a more detailed exposition of the fundamentals of Utilitarianism and criticism of the theory and practice, see Richard H. Popkin and Avrum Stroll, *Philosophy Made Simple* (second edition) Heinemann, 1981, page 37 ff. It is equally valid for the utilitarian to say: "the end justifies the means" which is a simpler expression of the philosophy. Clearly it also opens the door to what is often described as "The Slippery Slope."

<sup>19</sup> Popkin and Stroll, *op cit.*, page 1.

<sup>20</sup> Aristotle, *Nicomachean Ethics*, (trans J. A. K. Thomson) Penguin Classics, Penguin Books Ltd., 1953.

<sup>21</sup> Nadler, Steven, "Baruch Spinoza", *The Stanford Encyclopaedia of Philosophy* (Spring 2011 Edition), Edward N. Zalta (ed.), URL

= <http://plato.stanford.edu/archives/spr2011/entries/spinoza/>. I have no intention of making a critical analysis of Spinoza, (1632-1677) in this paper but it is sufficient to say that his controversial propositions in the 17th century provide the springboard for "modern relativism" particularly in the context of the examples cited above. See also Swoyer, Chris, "Relativism", *The Stanford Encyclopedia of Philosophy* (Winter 2010 Edition), Edward N. Zalta (ed.), URL <http://plato.stanford.edu/archives/win2010/entries/relativism/>.

<sup>22</sup> Dr Peter Hildering, President of the Netherlands Physicians League, addressing the UK House of Lords Select Committee in 2005 which was examining the Joffe *Patient (Assisted Dying) Bill*. Quoted in David Alton and Martin Foley, *Euthanasia: Getting to the Heart of the Matter*, St Paul's, 2005, pages 14-15. Coincidentally I recently heard of a Dutch lady now living in Canberra who made a similar observation. She has elderly relatives still living in the Netherlands. See also Martin Beckford, Health Correspondent, "Telegraph," 21 April 2010.

<http://www.telegraph.co.uk/healthnews/8466996/Fearful-elderly-people-carry-anti-euthanasia-cards.html>

<sup>23</sup> Marikyn Golden and Tyler Zoanni, "Killing us softly: the dangers of legalizing assisted suicide", *Disability and Health Journal* 3 (2010) 16-30.

<sup>24</sup> <http://www.publications.parliament.uk/pa/ld200506/ldbills/036/06036.i.html>

<http://www.spuc.org.uk/education/euthanasia/joffe/arguments.pdf>

<http://www.medlaw.oxfordjournals.org/content/15/1/126.extract>

<sup>25</sup> See also: John Keown, I.J. Kowen, "The Law and Practice of Euthanasia in the Netherlands," in *The New Law Quarterly Review*, 108, January 1992, pages 7-8. I am indebted to Deborah Dwyer BA (*cum laude*) MA (Smith) LL,B (ANU), LLMCL (NTU) for directing my attention to M. L. Allen's article in the *Brooklyn Journal of International Law* (see bibliography) in which he discusses the "doctrine of necessity" described by Deborah Dwyer as "an interesting legal defence in which a person argues that where there are two conflicting duties, one law can be violated so as to avoid violating another law or higher moral principle." She pointed out (email received on 25 August 2011) that "this is something that has not become an overarching legal principle in common law countries like Australia." She went on to write:

"Allen's discussion of the doctrine of necessity is very interesting (a legal defence in which a person argues that where there are two conflicting legal duties, one law can be violated so as to avoid violating another law or higher moral principle). This is something that has not become a major overarching legal principle in common law countries like Australia. Reliance upon the doctrine of necessity, especially when combined with a conceptual/philosophical approach to euthanasia that emphasizes it as a moral good, as compassionate or beneficent, means that the doctor's decision to ease someone's suffering (to the point of active killing) becomes the primary duty and is paramount; the

patient's autonomy takes second place. This assumes that some lives are not worth living and that the doctor always has the patient's best interests at heart and that euthanasia is better than death from a terminal disease, which is assumed to always be more painful than dying with so-called dignity via euthanasia. In terms of Dutch legal theory, Allen states, avoidance of suffering has come to override patient autonomy. I wonder if Australia could go the same way insofar as the principle of patient autonomy, sadly misused and abused by being dragooned into the role of dominant rationale for voluntary euthanasia, is drowned out as the chorus of the so-called "compassionate" grows louder and it could be that this "compassion" is eventually seen as far more compelling than any notion of autonomy or voluntariness.

Interestingly, patient autonomy was seemingly the underlying rationale in parliamentary debates about the well but unhappy over 70's in Holland, those who may have had enough of life and would like help to end their lives whenever they wished. At least the Royal Dutch Medical Association thought this was a step too far."

<sup>26</sup> David Alton and Marlin Foley, *op cit*, page 10.

<sup>27</sup> *Ibid.*

<sup>28</sup> A more complete analysis of the Netherlands attempts to legalize a regulated euthanasia program is discussed by Professor Margaret Sommerville, *Death Talk*, McGill-Queen's University Press, Montreal and Kingston, 2001, page146-150. Margaret Sommerville is the Samuel Gale Professor of Law, Professor in the Faculty of Medicine and founding Director of the Centre of Medicine, Ethics and Law at McGill University, Montreal, Canada. She is the author of a number of books addressing euthanasia from an ethical, legal and medical perspective. Her paper "Against Euthanasia" was the subject of the 2006 Massey lectures broadcast on *CBC Radio One* show "Ideas". She has recently concluded a number of speaking engagements in Australia at which she delivered a similar paper.

<sup>29</sup> [http://www.chninternational.com/breakdown\\_on\\_dutch\\_euthanasia.htm](http://www.chninternational.com/breakdown_on_dutch_euthanasia.htm)

<sup>30</sup> *ibid.*

<sup>31</sup> D.M.M. Francis, AO, OBE, in unpublished paper delivered to Year 12 students of St Edmund's College, Canberra.

<sup>32</sup> *Rights of the Terminally Ill Act 1995* (NT) (hereafter referred to as ROTTIA) came into effect on 1 July 1996. A challenge to that legislation in the Northern Territory Supreme Court resulted in a decision (by a majority of two to one) to uphold the law. An application for special leave to appeal against this decision to the High Court of Australia was heard in 1997. Legislation was tabled in the Northern Territory Legislative Assembly in an attempt to repeal the ROTTIA.

<sup>33</sup> The success of MHR Kevin Andrews' private member's Bill (*the Euthanasia Laws Bill 1997*) enabled Federal Parliament to override the ROTTIA.

<sup>34</sup> Dr. Philip Nitschke (born 8 August 1947) is an Australian medical doctor, humanist, author and founder and director of the pro-euthanasia group *Exit International*. He campaigned successfully to have a legal euthanasia law passed in Australia's Northern Territory and assisted four people in ending their lives before the law was overturned by the Federal government. Nitschke was the first doctor in the world to administer a legal, voluntary, lethal injection.

<sup>35</sup> *Australian Capital Territory (Self Government) Amendment (Disallowance and Amendment Power of the Commonwealth) Bill 2010* (the 'Territories Bill')

<sup>36</sup> With apology to Lerner and Lowe, *My Fair Lady*. (Musical)

<sup>37</sup> Discussions with Dr John Rosenberg, RN, PhD, MRCN, Foundation Director, Calvary Centre for Palliative Care Research and Senior Research Fellow, Australian Catholic University.

<sup>38</sup> "Assisted Death," *Lancet* 2, 1990, pages 610-13.

<sup>39</sup> *Op cit.*

<sup>40</sup> *Op cit.*

<sup>41</sup> *Op cit.*

<sup>42</sup> [www.dwdnsw.org.au](http://www.dwdnsw.org.au); [www.facebook.com/dwdnsw.org.au](https://www.facebook.com/dwdnsw.org.au); [www.twitter.com/DWDnsw](https://www.twitter.com/DWDnsw); and [www.youtube.com/dwdnsw](https://www.youtube.com/dwdnsw)

<sup>43</sup> "Dying with Dignity" (DWD), July 2011, page 2.

<sup>44</sup> For example in Sydney (Bishop Fisher v Dr Nitschke on 12 Aug 10 and in Canberra, 3 Aug 10, Dr Nitschke affirmed his support for "merciful" killing of defective infants, the unconscious and the non competent elderly. He said that the present law on euthanasia is unjust and "I have said that I will break it; unjust laws should be broken."

<sup>45</sup> Pro-euthanasia advocates *do* propose killing defective infants, the unconscious and the non-competent elderly and want legislation to approve the purchase by depressed teenagers of lethal pills from pharmacies so that they can commit suicide. (See Dr. Frank Mobbs [http://www.ad2000.com.au/articles/2003/oct2003p6\\_1453.html](http://www.ad2000.com.au/articles/2003/oct2003p6_1453.html) I believe that Dr. Nitschke has denied that he included depressed teenagers. However, see transcript of the Kathryn Lopez, *National Review Online*, Associate Editor, in her interview of Dr Nitschke on 5 June 2001 <http://old.nationalreview.com/interrogatory/interrogatory060501.shtml>. There is nothing ambiguous about his statement on page 4 with reference to "the troubled teen."

<sup>46</sup> DWD newsletter, July 2011, page 5.

<sup>47</sup> Professor Peter Singer's parents were Viennese Jews who escaped the Anschluss to Australia in 1938. Singer was born in 1946 in Melbourne, and went to Melbourne University, where he studied law, history, and philosophy, graduating in 1967. Having received an M.A. in 1969 (with a thesis on "Why should I be moral?"), he went on a scholarship to University College, Oxford to do the B.Phil., which he took in 1971. Singer's philosophies are deeply entrenched in Utilitarianism (see Definition No. 9.) from which he develops his attitude to abortion, infanticide and measuring the value of human life by the degree of its on-going contribution to society.

<sup>48</sup> Mobbs, *ibid*.

<sup>49</sup> *National Review Online, ibid*.

<sup>50</sup> Jonathon Lynn and Antony Jay, "Yes Prime Minister", BBC Television, 1980-1982 and 1984. Program on Opinion Polls <http://www.youtube.com/watch?v=3gMcZic1d4U>

<sup>51</sup> Pollard, *op cit.*, page 60.

<sup>52</sup> Kuhse and Singer P, "Doctors' practices and attitudes regarding voluntary euthanasia." *Medical Journal of Australia*, 1988, 148, pages 623-626.

<sup>53</sup> DWD Newsletter, July 2011.

<sup>54</sup> *Ibid*, page 4. This claim was made in an effort to refute Premier Barry O'Farrell's statement that his political view, which included his opposition to euthanasia, was "mainstream" not "extreme."

<sup>55</sup> See <http://www.euthanasia.com/page13.html> for a list of those who have commented.

<sup>56</sup> *Ibid*, page xv.

<sup>57</sup> Venerable L. Sri Dhammamanda Maha Thera, "Noble Eightfold Path – The Middle Way". The English translation may be found in <http://www.sonc.sunysb.edu/Clubs/buddhism/>. Specifically, moral conduct (Śīla) prescribed in Right Action includes "we should abstain from taking a life which we ourselves cannot give..."

<sup>58</sup> William F. Sullivan, MD, PhD and John Heng of the Plunkett Centre for Ethics, in "Bioethics Outlook," Vol 22 No 2, June 2011, page 5.

<sup>59</sup> See also Thomas Aquinas, *Summa theologiae*, II-II, q.64.5; *De regno, ad regem Cypru* I.1, n. 8.

<sup>60</sup> "Euthanasia Sets Sail" an interview with Philip Nitschke, the other Dr. Death by Kathryn Lopaz, *National Review* associate editor, June 5, 2001.

Transcript from <http://old.nationalreview.com/interrogatory/interrogatory060501.shtml>.

<sup>61</sup> <http://www.un.org/en/rights/>

<sup>62</sup> It seems clear that there are some cases where the administration of morphine in massive doses has resulted in the sought outcome - death of the patient. In such cases it is intentional and therefore it is euthanasia. It is far more usual that morphine is administered only in sufficient quantity to address the pain appropriately. I am unaware of any cases of patients in Australia, to whom the correct medical dose was given, dying from anything other than the underlying condition. But they died in a sedated state.

<sup>63</sup> Dr. Brian Pollard, "Palliative Care – Is it the Answer?" in Jeremy Stuparich, *Euthanasia, Palliative and Hospice Care and Terminally Ill*, record of Seminar held at John XXIII College, Australian National University, 26 September 1992, pages 1-16. <http://www.actrtla.org.au/euth/bookeu/pollard.htm#E12E3>

<sup>64</sup> *op cit.*, page 5.

<sup>65</sup> Daniel P. Sulmasy, "Human Dignity and Bioethics: Essays Commissioned by The President's Council of Bioethics," 2008, and his contribution to the Fourth International Colloquium of International Association of Catholic Bioethicists, 12-16 July 2009 at Kardinal-Schulte-Haus, Germany.

<sup>66</sup> <http://www.who.int/cancer/palliative/painladder/en/index.html>

<sup>67</sup> Pollard, (1989) *op cit*, page 86-87.

<sup>68</sup> Pollard, *ibid*.

<sup>69</sup> Rosenberg, *ibid.*

<sup>70</sup> Rosenberg, *ibid.*

<sup>71</sup> Over 2,500 years ago Hippocrates of Cos formulated an ethical position to be adopted by doctors in the care of their patients. The doctor was required to take an oath that stated *inter alia*: "I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." In Australia one would like to think that this ethic continues to be respected. If a properly conducted survey was conducted today to test this, I suspect that it would be upheld by society at large. But how such an ethic can continue to be respected and legally protected in a society in which euthanasia is lawful is a matter that has, so-far, eluded legislators elsewhere.

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