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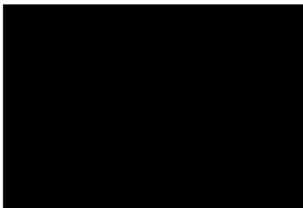
The Secretary  
Legislative Council Standing Committee on Social and Legal Issues,  
Parliament of Victoria

**Inquiry into End of Life Choices**

Thank you for your letter of June 3 in which you invited me to make a submission to your Inquiry.

I am pleased to enclose my submission.

Sincerely,



Peter Singer  
Ira W. DeCamp Professor of Bioethics, Princeton University  
Laureate Professor, University of Melbourne

## **Submission to the Inquiry into End of Life Choices**

**Parliament of Victoria, Legislative Council, Standing Committee on Legal and Social Issues**

**Peter Singer, AC**

**Ira W. DeCamp Professor of Bioethics, Princeton University, Princeton, New Jersey**

**Laureate Professor, School of Historical & Philosophical Studies, University of Melbourne.**

### *1. The Ethics of Ending Life*

There are, in my view, two distinct grounds for amending existing law to permit a wider range of end of life choices. They relate to the two principal reasons why we normally consider killing someone to be both morally wrong and a serious crime.

The first reason why we normally consider killing someone to be morally wrong is that it is a violation of the autonomy of the person killed. Yet clearly, this reason applies only when the person wants to go on living. The nineteenth century philosopher John Stuart Mill argued that individuals are, ultimately, the best judges and guardians of their own interests. So, in a famous example, he said that if you see people about to cross a bridge you know to be unsafe, you may forcibly stop them in order to inform them of the risk that the bridge may collapse under them, but if they decide to continue, you must stand aside and let them cross, for only they know the importance to them of crossing, and only they know how to balance that against the possible loss of their lives. Mill's example presupposes, of course, that we are dealing with beings who are capable of taking in information, reflecting and choosing. I also hold that Mill's principle applies only to considered choices about which people may reasonably differ. (It does not apply, therefore, to matters like wearing seatbelts, or bike helmets, where, if people do

not make use of these safety devices it is from laziness or poor habits rather than after careful reflection on the relevant information.

In the case of an end of life decision, the value we place on individual liberty counts in favor of allowing the person whose life it is to be the one to decide if that life is worth continuing. This value might not always override all other values – for example, it does not follow that we should allow lovesick young adults the freedom to end their lives because the one they love has rejected them. In those circumstances we can safely predict that the present mood will pass, and that the young person will, in future, consider life worth living. We could then consider that the young person's judgment is temporarily impaired and hence ought not to be given full weight, and we could reasonably conclude that under these circumstances the loss of the future value of that life overrides the value of individual liberty.

This case suggests the second reason why we normally consider killing both morally wrong, and a serious crime: killing deprives that person of whatever good things she or he would have experienced over her or his remaining lifetime. When, however, a person can reasonably expect no future good experiences, or whatever good the person can expect is decisively outweighed by bad things, such as suffering, loss of dignity, feelings of helplessness, and so on, then this ground for holding killing to be wrong and a crime does not apply. This will normally be the case when a person is terminally ill and, with unimpaired capacities for judgment, comes to the conclusion that his or her future is so clouded that it would be better to die than to continue to live. Indeed, in these circumstances the usual ground for holding killing to be wrong because it deprives the person of good experiences is turned into its opposite, a reason for acceding to that person's request because it will save the person from bad experiences. This may be the case when a patient is terminally ill, or is suffering from an incurable condition that the patient finds makes life unbearable.

For these reasons, I advocate a change in the law to allow both physician-assisted suicide, as the law allows in Switzerland, Oregon, Washington, Montana and Vermont,

and as will soon be permitted in Canada, and also voluntary euthanasia, as in the Netherlands, Belgium, Luxembourg, and Colombia. I do not consider that there is any significant moral difference between physician-assisted suicide and voluntary euthanasia. If the former is more politically acceptable than the latter, it would be possible to legalize only the former. The disadvantage of this procedure is that people who are unable to swallow – for example, because they are suffering from esophageal cancer – and request assistance in dying could not be assisted.

To a minority of the Victorian community, both physician-assisted suicide and voluntary euthanasia will be morally unacceptable. Their views are, however, implicitly respected because they are, of course, under no obligation to take part in it. It is an *option* (like palliative care and the withholding of treatment) available to those who want it, and is not a mode of dying that must be taken up by everyone. Similarly for physicians, those with conscientious objections may simply inform their patients of their views, and should be under no pressure to be involved in physician-assisted suicide or voluntary euthanasia.

Two objections to the legalization of physician-assisted suicide and voluntary euthanasia have been prominent. The first is the slippery slope argument. The second is the claim that palliative care has developed to a point at which there is no need for active assistance in dying.

### *Objection (1): The Slippery Slope Argument*

When, in the 1970s, I first became interested in the ethics of end of life decision-making, opponents often claimed that once it became permissible for physicians to end the lives of their patients, or help their patients to end their lives, this would be the start of a slippery slope that would lead to much more widespread killing. It was even said that a society that took this step would soon slide all the way down to a Nazi-like state in which people considered politically and ethnically undesirable would be killed. These predictions were never very plausible, but there was more plausibility to the claim that

elderly or vulnerable people might come under some pressure to end their lives. At that time no state permitted the open practice of voluntary euthanasia or physician-assisted suicide, so it was not possible definitively to refute this claim.

Now that we have many years of experience with legal voluntary euthanasia and physician-assisted suicide, such fears can be demonstrated to be unfounded.

I recommend that the committee study the judgment of Justice Lynn Smith, in *Carter v Canada*, a case in which the judge, carefully examined a very wide range of evidence from the Netherlands, Belgium, Oregon and other jurisdictions about the slippery slope argument. Here is Justice Smith's conclusion:

[1366] An absolute prohibition [of physician-assisted suicide] might be called for if the evidence from permissive jurisdictions showed abuse of patients, or carelessness or callousness on the part of physicians, or evidence of the reality of a practical slippery slope.

[1367] However, that is not what the evidence shows. I have found that the evidence supports the conclusion that a system with properly designed and administered safeguards could, with a very high degree of certainty, prevent vulnerable persons from being induced to commit suicide while permitting exceptions for competent, fully-informed persons acting voluntarily to receive physician-assisted death.<sup>1</sup>

On appeal, the Supreme Court of Canada unanimously upheld Justice Smith's ruling, and on the particular point from which I have quoted, commented as follows:

The trial judge made no palpable and overriding error in concluding, on the basis of evidence from scientists, medical practitioners, and others who are familiar with end-of-life decision-making in Canada and abroad, that a permissive regime

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<sup>1</sup> *Carter v Canada (Attorney-General)* 2012 BSC 886, pars 1366-7, available at <https://bccla.org/wp-content/uploads/2012/06/Carter-v-Canada-AG-2012-BCSC-886.pdf>

with properly designed and administered safeguards was capable of protecting vulnerable people from abuse and error.<sup>2</sup>

This is, I believe, a fair and balanced assessment of the evidence regarding the view that permitting physician-assisted suicide or voluntary euthanasia will endanger vulnerable patients.

*Objection (2): Does Palliative Care Render Assistance in Dying Superfluous?*

Some palliative care specialists regard a request for assistance in dying as a sign that they have failed to provide adequate palliative care. They claim that palliative care can always eliminate the need for physician-assisted suicide or voluntary euthanasia. This is only true, however, if we count the practice known as “terminal sedation” as a form of palliative care. In terminal sedation, the patient is sedated to the point of long-term unconsciousness, and is given no medical treatment. The unconscious patient does not demand food or fluids, and tube feeding is deemed to be medical treatment and is not provided. Such a patient will, of course, die without recovering consciousness. I see no moral difference between this and euthanasia, except that in this situation, where terminal sedation is not regulated by law, it is more likely to be performed without proper informed consent than physician-assisted suicide or voluntary euthanasia under a system of regulation such as exists in Oregon or the Netherlands.

I have no information about the practice or the legality of terminal sedation in Victoria. It is significant, however, that a survey of 677 Connecticut members of the American College of Physicians found that 78% of respondents believed that if a terminally ill patient has intractable pain despite aggressive analgesia, it is ethically appropriate to provide terminal sedation. About half of these also agreed that physician-assisted

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<sup>2</sup> *Carter v Canada (Attorney-General)* [2015] 1 SCR 331.

suicide is ethically appropriate in some circumstances. The other half, I believe, were fooling themselves.<sup>3</sup>

A report commissioned by the Royal Society of Canada looked at the question of whether the demand for assistance in dying exists only where palliative care is inadequate. Here is its conclusion on this issue:

Data from the Netherlands, Belgium, and Oregon show that the need for assisted death is only partly dependent on the quality and availability of palliative care. Patients ask for assisted suicide or euthanasia not only because they are in pain but also because they evaluate their own situation as undignified. Patients ask for assisted suicide for reasons relating to autonomy and their own perceived quality of life. Palliative care would be able to respond to such concerns in some but certainly not in all cases. And even if it is the case that better palliative care would take away some of the need for assisted dying, it does not follow that a society should wait to have a policy on assisted dying until palliative care is optimized. It would constitute a reason for working on these improvements, but not a valid reason for telling people who are suffering right here and now to wait until these improvements have been realized.<sup>4</sup>

Some of Australia's leading palliative care specialists have acknowledged that physician-assisted suicide or voluntary euthanasia has a place in end-of-life care. Dr Roger Hunt is a pioneer of hospice development in South Australia and a former

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<sup>3</sup> L.C. *Kaldjian et al*, "Internists' attitudes towards terminal sedation in end of life care," *Journal of Medical Ethics*, 30(2004):499-503.

<sup>4</sup> Udo Schuklenk, et al, "End-of-Life Decision-Making in Canada: The Report by the Royal Society of Canada Expert Panel on End-of-Life Decision-Making" *Bioethics*, 25 (Supplement S1) (2011) pp, 1-73.

Chairperson of the SA Association for Hospice and Palliative Care. Writing in *The Age*, he has said:

I believe palliative care will never eliminate all suffering - this is an impossible dream. Currently, terminally ill patients experience an array of distressing symptoms despite the provision of state-of-the-art palliative care. For example, patients commonly experience progressive weakness, which causes loss of function, diminished quality of life, and dependence, and there is no effective treatment to increase their strength. I've also witnessed people suffering disfigurement, nausea, suffocation, incontinence, pain, psychological distress, confusion and more. Sometimes dying can be horrifying...I have become convinced there is a small but definite place for euthanasia in terminal care.<sup>5</sup>

Professor Michael Ashby, a Past President of the Australia and New Zealand Society for Palliative Medicine (ANZSPM) and a past Chairman of the Chapter of Palliative Medicine at the Royal Australasian College of Physicians supports the legalization of voluntary euthanasia or assisted suicide. He denies that such moves are dangerous, and adds "When death is done well, families grieve better."<sup>6</sup>

Of course, not everyone will want or need anything more than palliative care. Palliative care can give many people the kind of dignified death they want. This does not mean, however, that it is appropriate for everyone. So it is scarcely relevant to argue, as many do, that there are few terminally ill patients who cannot be helped by palliative care. The figure may be as low as 5%. The fundamental point would still stand even if the percentage were only 0.05%: no patient should be made to die in ways that, while meeting the moral or religious precepts of some, are anathema to their own.

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<sup>5</sup> Roger Hunt, *The Age*, October 10, 1996.

<sup>6</sup> *MJA Careers*, <https://www.mja.com.au/careers/199/3/steady-hand-dying>