

From:
To: [LSIC](#)
Subject: RE: Submission of the Victorian Secular Lobby, Inc., to the Legal and Social Issues Committee of the Victorian Parliament Concerning End of Life Choices
Date: Wednesday, 14 October 2015 11:56:47 PM

The following is the submission of the Victorian Secular Lobby, Inc., (A00594400A) to the Legal and Social Issues Committee of the Victorian Parliament Concerning End of Life Choices, as determined by the committee of the Association and with input from members.

Yours sincerely,

Lev Lafayette
President
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1. Status of the Submission

On 7 May 2015 the Legislative Council agreed to the following motion:

"That pursuant to Sessional Order 6 this House requires the Legal and Social Issues Committee to inquire into, consider and report, no later than 31 May 2016, on the need for laws in Victoria to allow citizens to make informed decisions regarding their own end of life choices and, in particular, the Committee should

- (1) assess the practices currently being utilised within the medical community to assist a person to exercise their preferences for the way they want to manage their end of life, including the role of palliative care;
- (2) review the current framework of legislation, proposed legislation and other relevant reports and materials in other Australian states and territories and overseas jurisdictions; and
- (3) consider what type of legislative change may be required, including an examination of any federal laws that may impact such legislation.

This submission is a contribution by the Victorian Secular Lobby, Inc. The Victorian Secular Lobby is incorporated in the State of Victoria, Number A00594400A

2. Definitions Used In This Submission

In this submission the following definitions are used:

Euthanasia is defined in this submission as action or inaction that directly and deliberately causes the patient's death. As the Legislative Council motion concerns itself with end of life choices, the submission is

orientated towards issues surrounding voluntary euthanasia, defined as situations where the death of a person occurs with their competent and informed consent. This is distinguished from non-voluntary euthanasia (e.g., the person is comatose, some instances of the Groningen Protocol of the Netherlands) and involuntary euthanasia (e.g., killing contrary to the subject's wishes).

A person who makes competent and informed consent understands their condition at an end of life situation and is able to make a rational decision on the choices available to them.

Passive and active euthanasia are distinguished, the former representing inaction by another party with results in a death (e.g., withholding life-sustaining medicine), whereas the latter consisting of actions that result in death. This difference is primarily a matter of actor intention, as pragmatically the outcome is the same. A subset of active voluntary euthanasia are actions by another party which the means are provided so a person may commit suicide.

Dignity is defined as a situation where a person has control and independence over their life and body.

Palliative care is medical or other care given to a terminally ill person which is aimed in reducing suffering.

3. Legal Standing and Practise of Voluntary Euthanasia

Under the Victorian Crimes Act (1958), a party engaging active voluntary euthanasia could be prosecuted for murder or manslaughter (s3., s5., s6B, s22), although it is quite evident that this is very rarely enforced. A recent investigation was carried out in March 2015 following the death of a member of the group Exit International. [1]

The Victorian Medical Treatment Act (1988) establishes the right and procedure of patients to refuse medical treatment, allowing for passive voluntary euthanasia. In addition, under English common law, a doctor may administer pain killers to a terminally ill patient to relieve suffering, knowing that this may shorten a patient's life, provided that the primary reason is this relief, rather than to cause death [2].

In 1996, the world's first euthanasia legislation, the Rights of the Terminally Ill Act (1996), was passed in the Northern Territory of Australia. The legislation was overturned by the Commonwealth by the Euthanasia Laws Act 1997, which led to the establishment of Exit International. The Commonwealth government subsequently further hindered voluntary active euthanasia with the passage of the Criminal Code Amendment (Suicide Related Materials Offences) in 2004.

Internationally, some form of voluntary euthanasia is legal in Belgium, Luxembourg, the Netherlands, Switzerland, Canada, and the U.S. states of Oregon and Washington.

In the Netherlands, euthanasia is carried out under the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act" (2002). These legislative considerations include the patient's request, the patient's suffering (unbearable and hopeless), the information provided to the patient, the absence of reasonable alternatives, consultation of another physician and the applied method of ending life and reporting to a review committee.

In Canada, a decision of the Supreme Court on February 6, 2015 limits physician-assisted suicides to "a competent adult person who clearly consents to the termination of life and has a grievous and irremediable medical condition, including an illness, disease or disability, that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition."

4. Public and Political Opinion

Numerous public opinion surveys [3] in Victoria have indicated overwhelming support for voluntary euthanasia with as little as 14% disagreeing from a voluntary survey of over 60,000.

An opinion poll conducted by Newspoll in 2009 showed that 84% of surveyed

Victorians supported voluntary euthanasia.

An opinion poll conducted in Newspoll in 2012 indicated that 86% of surveyed Victorians supported voluntary euthanasia with 11% opposed.

An opinion poll conducted by Fairfax Ipsos in 2014 indicated that 76 per cent supported a change to laws that ban assisted suicide and euthanasia.

A particular public which must be referenced is, of course, those who are seeking active voluntary euthanasia. This policy issues affects such people more deeply than any other correspondents. Overwhelmingly the plea is for the opportunity to make an end-of-life choice in a many that is dignified and of their own volition.

Political parties represented in the Victorian parliament (the Australian Greens, the Australian Sex Party) have policy positions supporting voluntary euthanasia.

5. Non-Secular Arguments

Non-secular arguments for or against euthanasia are those which derive their justification not on evidence on the most effective relief of suffering, or on a sense of autonomy of an individual, or on beneficial or negative social norms, but rather an appeal to articles of faith inspired by metaphysical presumptions.

In 2011 the Australian Bureau of Statistics reported [4] that 61% of the Australian population were of the Christian faith, the major denominations being Catholic (25.3%), Anglican (17.1%) and Uniting (5.0%). Non-Christians made up 7.2% of the population (Buddhism 2.5%, Islam 2.2%), and 'No Religion' was specified by 22.3%.

Dealing with the the smaller, non-Christian religions first, the panca sila of Buddhist specifies not to kill any living being; however the Vakkali Sutta and Channa Sutta both give examples where terminally ill monks, already well progressed on the path to enlightenment, engage in suicide as a suitable course to reduce suffering and carried out with mindfulness. With regards to Islam, there are doctrinal suggestions against active euthanasia (Qur'an 4:29, 17:33), however the Islamic Code of Medical Ethics and the to the Islamic Medical Association of America (IMANA) both make statements in favour of passive euthanasia, but only where there is no chance of patient recovery (Shabih H. Zaidi, Ethics in Medicine, 2014).

The Catholic Church regards active voluntary euthanasia as morally wrong as God has jurisdiction over life. The encyclical *Evangelium Vitae* (Pop John Paul II, 1995) argues: "in harmony with the Magisterium of my Predecessors and in communion with the Bishops of the Catholic Church, I confirm that euthanasia is a grave violation of the law of God, since it is the deliberate and morally unacceptable killing of a human person". Nevertheless, passive voluntary euthanasia is acceptable, drawing a distinction between using ordinary means to preserve life as distinct from extraordinary means (Gerald Ford, S.J., in John Dedek, *Human Life: Some Moral Issues*, 1972, pp.125-26).

The position of the Anglican Church is similar. As determined by General Synod Resolution 46/95, and Lambeth Resolution 1.14 (1998) life is considered as a gift from God that has intrinsic sanctity, and therefore not subject to human choices but distinguishes between active euthanasia and "withholding, withdrawing, declining or terminating excessive medical treatment and intervention". The General Synod Resolution specifically recommended that state parliaments vote against legislation to legalise euthanasia.

In some contrast, the Uniting Church argues that "there is no one ethical stance but rather a range of views that come from each person's understanding and experience of their faith" and argues that there may be exceptional situations where pain and distress affects quality of life to the extent that active euthanasia would be justified [5].

It is the opinion of this submission that all non-secular Arguments should be rejected by the committee. It is not the role of the Victorian government to determine what religious doctrine of faith its residents

should adhere to in any circumstances. Whilst the above claims may provide a basis for particular actions and views for individuals within a faith, it is not universally shared.

A sensitivity to religious pluralism within our society does not mean that legislation should be enacted that is captured by it, even in the sense of being a compromise between competing articles of faith. Rather, secular laws must apply independently to such articles and be based on shared norms informed by factual evidence alone.

6. Universal Norms and Evidence-Based Research

It is important to realise that the Victorian Secular Lobby or its members do not necessarily reject any of the claims from various religious groups. However, we do recognise that these are articles of faith, rather than statements of evidence. Life may very well be a gift of a divine creator with intrinsic value; it may also be that this life is a period of unnecessary and cruel suffering (e.g., dukkha in Buddhism) instituted by a malicious supernatural being (dystheism).

If the intrinsic value of life is not something that is subject to accurate human evaluation in itself, then governments should not legislate on it. Instead the universal reality in which governments can legislate in this context would involve (a) the existence of individual reasoning minds and bodies and (b) the existence of varying degrees of pleasure and pain experienced by those bodies. If these principles are accepted - and it is difficult to deny the independence of human biological entities - then political rights should be accorded that respects individuals.

This argument of individual rights to life choices is, of course, tempered in each case by social obligations that the individual may have; a decision to die by euthanasia will affect other people (e.g., friends, family, health care professionals). However it is not the role of government to determine whether an individual has engaged in sufficient consideration of such people when making a decision concerning their own end of life choices.

A genuine secular concern exists that if active voluntary euthanasia is decriminalised, then an opportunity exists for involuntary euthanasia through subtle pressure by medical professionals. However the existence of a logical argument for this "slippery slope" differs from the empirical evidence that the argument implies. For example, non-voluntary euthanasia levels have remained stable (at less than 1% of total deaths) in the Netherlands following decriminalisation of voluntary euthanasia (<http://euthanasia.ws/hemeroteca/pendientelewis.pdf>).

A related argument is the criteria is the question of mental competence to express a desire to die (e.g., whether it is enduring or a temporary despairing suicidal urge). Whilst this can be avoided in most cases by a repeated expression over a period time to determine this enduring wish, a contrary position could argue a person in consistent pain or dependence is unable to make a rational choice. This unfairly places a person making end-of-life choices in a situation where the very conditions that would cause a desire for voluntary euthanasia lead to its prohibition.

A further argument against active voluntary euthanasia is the suggestion that good palliative and hospice care can be applied instead of voluntary euthanasia options. In part this is a false dichotomy, because the two issues are not contradictory; both good palliative and hospice care can be offered in addition to active voluntary euthanasia. Further palliative care, often based on a level of trial and error, does not necessarily enable an easeful death or even is certain to reduce suffering or a sense of dependence. Indeed, in a number of cases there is no effective palliative care (e.g., motor neuron disease, asbestosis).

7. Recommendations

The Victorian Secular Lobby, Inc., has two main related positions which it advocates as part of its own objectives. It is outside of our organisation's objectives and policies to make further recommendations, and as such much of this submission is designed to be informative rather than prescriptive. Nevertheless there are two important considerations of which the association wishes to raise as a priority.

Firstly, is that the Legal and Social Issues Committee of the Victorian Parliament must explicitly reject any attempt by religious organisations to apply non-secular arguments into deliberations of these medical and normative issues. This is not to imply any exclusion from public debate by religious organisations but rather to ensure that participation in moral and political debate uses language and arguments that are at least in principle accessible to all in order to make an independent and universally applicable rational choice.

Secondly, that the evaluation of practises, review of the current framework of legislation, and proposed legislation, are based on strict ontological definitions, empirical evidence, and based on the universal norms. Based on the evidence that has been reviewed, there is a very strong case for recognising bodily autonomy as part of end-of-life choices, especially when medical professionals are able to evaluate the individual's state of mind and probability of enduring circumstances. Available evidence suggests that legislative amendments which provide for active voluntary euthanasia does not result in a "slippery slope" leading to non-voluntary or involuntary euthanasia by medical professionals.

References

[1]

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[4]

<http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/2071.0Main%20Features902012%E2%80%932013>

[5] A Call for Compassion in the Euthanasia Debate,

<http://unitingchurchwa.org.au/blog/2010/09/a-call-for-compassion-in-the-euthanasia-debate/>