Plunkett Centre for Ethics
A joint centre of St Vincent’s Health Network Sydney and Australian Catholic University.

Submission to Victorian Parliament
Legislative Council’s Standing Committee on Legal and Social Issues
Inquiry into End of Life Choices

1 I would like to express my appreciation to the Committee for inviting me to make a submission to its Enquiry. I seek the opportunity further to explain the points in this submission to the committee in person.

2 I recommend that, in its deliberations and its recommendations, the Committee insists on clarity in language.
   a. Terms such as ‘aid in dying’ or ‘dying with ‘dignity’ are tools of obfuscation. They are meant to confuse the very important legal and social issues you are addressing. They are meant to suggest that, were the parliament to legalize assistance in suicide and euthanasia, it would be legalizing something that is already a part of (good) medical practice.
   b. But terms such as ‘aid in dying’ or ‘dying with dignity’ do not distinguish between, on the one hand, relieving someone of their pain and suffering by giving drugs, in a dosage determined by the drugs’ capacity for relief of pain and suffering, foreseeing that the drugs in that dosage will cause death and, on the other, deliberately killing someone with drugs to relieve the person of pain and suffering. The former is a standard part of good medical care, which (without involving any intention on the part of the doctor to kill the person) aids that person in dying. The latter, that is, the deliberate, intentional bringing about of death in order to relieve suffering - which is what proponents of legalization wish to see legalized - is not.
   c. Some proponents of the legalization of assistance in suicide and euthanasia have the admirable honesty to refuse to obfuscate the issues by using terms such as ‘aid in dying’ and ‘dying with dignity’. They want a change in the law but they insist on arguing for that change in straightforward language such as ‘assisting a person to commit suicide’ and ‘deliberately killing someone with drugs to relieve the person of pain and suffering’ (‘euthanasia’). Others are not so forthright.

1 One such proponent – Ronald Dworkin - pointed out recently that he thought it ‘just a lie’ to name an underlying disease as the cause of death in cases of assistance in suicide or euthanasia http://www.3quarksdaily.com/3quarksdaily/2015/06/california-dying.html
d. The Committee should be aware that, as the obfuscating terms increase in usage (from ‘euthanasia’ to ‘assistance in suicide’ to ‘dying with dignity’ to ‘aid in dying’ etc) the percentage of the community which is said to be in favour of a change in the law also increases. This indicates that people often do not know what they are being asked to support.

e. I hope that you will not legalize ‘assistance in suicide’ and ‘euthanasia’. But I also hope that, in your deliberations, you will insist on honesty in language.

3 I recommend that the Committee appreciate why it is necessary to understand the distinctive nature of medical practice.

a. In the Hippocratic Oath, medicine is understood as a particular (‘goal-oriented’) activity: the healing of the sick. This idea derives from the meaning of medicine itself. The doctor’s essential activity is that of healing (‘making whole’, which might take the form of illness-prevention, cure, stabilization, relief of symptoms, improving the way the person dies, etc).

b. It follows that neither helping a person to kill himself/herself nor doing that for the person can be made consistent with medicine’s own meaning.

c. This idea, that medicine has its own distinctive meaning, is rejected by some (in favour of a ‘doctor as provider’ and ‘patient as consumer’ model according to which medicine is to be understood simply as a set of techniques, skills, etc which can be put to any purpose).

d. But we need to know what is distinctive about medicine if we are to deal with its complexities.
   i. What should a doctor do if he is asked to see a patient with profound neurological damage but who is not dying?
   ii. What should paediatricians do if the parents of a child with profound developmental disability ask them to inhibit their child’s growth?
   iii. What should the profession do if the government wants it to supervise/conduct capital punishment?

e. So I respectfully urge the committee to appreciate the distinction between (a) a doctor ensuring that (i) the choice about what authentic objective should be pursued and (ii) the means used to pursue that objective both reflect the choices of the patient, and (b) the doctor using medicine’s techniques and skills to pursue whatever purpose the patient chooses.

4 I recommend that the Committee examine whether medical care at the end of life care is as good as it ought to be in Victoria. To determine this, the committee needs to assure itself of the following:

a. That the medical profession is able to show that
i. it is continually developing and refining its knowledge of, and techniques in, the relief of pain and of the other symptoms of illness (breathlessness, constipation, anxiety, depression, loss of lucidity, etc); and

ii. any refusal of life-sustaining treatment is respected, and that doctors are prepared to relieve pain and other symptoms of illness even in circumstances in which that will hasten death: doctors should be fully committed to withdrawing or withholding life-sustaining treatment which has become futile (a medical decision), overly-burdensome (a patient’s decision) or just refused (again, a patient’s decision).

b. that training institutions are ensuring that the students they train emerge from that training having mastered the best and most effective techniques for the relief of pain and other symptoms of illness;

c. that the public health system, and the residential care system, is such that all Victorians, whatever their financial means or the geographical location, have ready access to the best palliative care in which are found the most effective techniques for the relief of pain and of the other symptoms of illness at the end of life.

5 If the Parliament were to legalize assistance in suicide and euthanasia, it should insist that they not be conducted by the medical profession, but should ensure that they are conducted by some other body of skilled persons (‘euthanatists’).

a. These practices violate the nature and goals of medicine. Medicine’s nature and goal is to heal (in the richest sense of that word: sometimes to cure, sometimes to stabilize a patient in an ‘all things considered’ reasonable state, sometime to relieve symptoms, sometimes to attend to the psychological and existential needs of the dying person, etc). Whilst doctors should be fully committed to withdrawing or withholding life-sustaining treatment which has become overly-burdensome, the doctor’s profession is to heal (to ‘make whole’) the sufferer, not to do away with the sufferer.

b. Permitting doctors to undertake these practices would damage the trust essential to the patient-doctor relationship. Once these options are on the table, it becomes difficult for patients not to question the motive of the doctor who is committed to healing but now has the power to kill him or her. How could the patient be confident that, when for example, the doctor says that another CT scan is or is not needed, the doctor truly has the well being of the patient in mind?

c. Permitting doctors to undertake these practices will have a detrimental effect on the moral psychology of the medical profession. The law of infinite regress means that the ‘indications’ for assistance in suicide or euthanasia will be widened. (There is ample evidence of fact of slippery slope in every expanding set of indications for euthanasia in Netherlands and Belgium.) It will encouraged
doctors to think there is a medical answer to all human problems. It will allow doctors to work out their own concerns about mortality on their patients. Anyone who says ‘that won’t happen in Victoria’ does not appreciate the weakness of human will.

6 The Committee needs to appreciate the ‘logical’ slippery slope from euthanasia when it is voluntary to euthanasia when it is non-voluntary.

a. The reasoning which leads a doctor to accept euthanasia when it is voluntary commits him or her to accepting it when it is non voluntary.

b. That reasoning is: ‘Death would be a benefit to this patient.’ That is why a doctor acquiesces in the patient’s request. That is the doctor’s reasoning. If the doctor did not think the request reasonable, he or she would refuse to acquiesce to it.

c. If the doctor can make this judgment in the case of a patient who requests it, he can just as well make this judgment in the case of someone who does not or cannot request it.

d. If death would be a benefit to one person (the person who requests it), why deprive another person of that benefit just because he or she is not able to request it? Or just because he or she does not have a ‘terminal’ illness?

e. Some proponents of legalizing euthanasia forthrightly accept this logical point. Peter Singer, for example. Others are less forthright. 2

f. This is why some proponents are prepared to say that it would be ‘unfair’ to deprive some people of this ‘benefit’ by making the conditions on which it can be obtained too hard.

g. It is why Elizabeth Anscombe pointed out that the legalization of euthanasia was only a ‘way station’. 3

2 Rodney Syme: ‘At the moment, we are struggling to get legislation to get legislation for what is a very much simpler problem, and that is the person who does have clearly demonstrable competence, who is perfectly rational, and I don’t think that we should muddy the water in any way with discussions about dementia. Ultimately, if society deems that laws for people who are rational and competent are appropriate, it may well be that society will eventually see that is perhaps an unfair situation, that people with dementia ought to be considered. And we will work out some mechanism for dealing with that. But in my opinion that will be 20 or 30 years in the distance.’ ABC Radio National, Australia Talks, 26th June 2008, Repeated ABC Radio National Encounter Program, A Modern Death: 23 November 2013

3 ‘So far, most propaganda for euthanasia assume it should be voluntary... this is only a way-station. But it impresses, because it strikes people as not wrongdoing someone to kill him if he will it. However, it needs pointing out that they would still think it was wrongly him, but for the accompanying judgment that his condition is so irremediably wretched that it is fortunate for him ‘to die’. This judgment is paramount, and that is why the stress on voluntariness tends to be spurious. Though some people are serious about it, upon the whole it is merely getting the foot in the door. The drive is in the direction of killing people when their lives are judged useless or burdensome to themselves
h. It is why there is increasing evidence of an actual slippery slope in the European countries which have legalized assistance in suicide and euthanasia when it is voluntary, evidence which is increasingly accepted by proponents of legalization.4

i. Once you appreciate this ‘logical’ slippery slope, you will see that it will not be possible for Victoria to maintain a line between euthanasia when voluntary and euthanasia when non-voluntary. Once you legalize the former, the pressure to legalize the latter will come out into the open.

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